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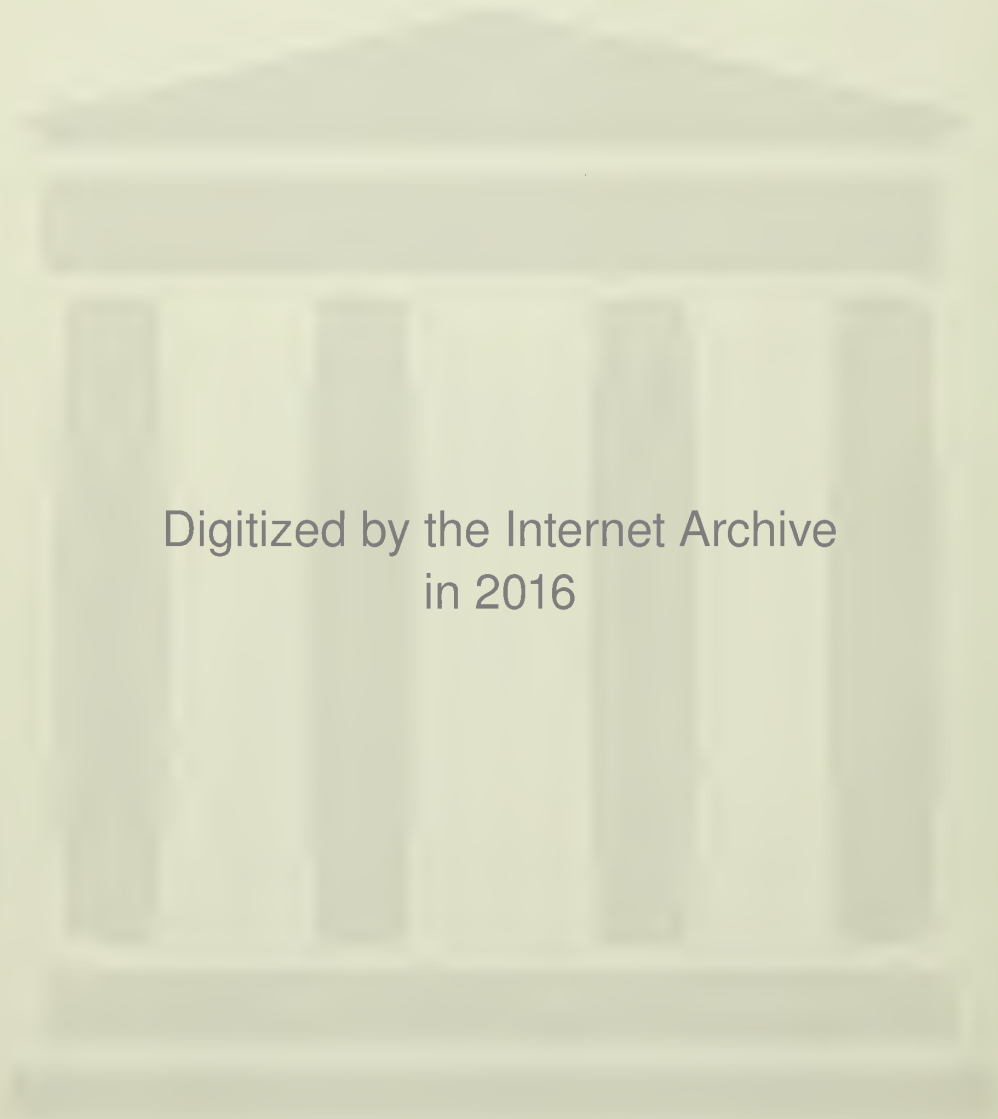
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pennsylvania medicine

January 1975

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Pennsylvania Delegation to the AMA

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January 1975 Volume 78, Number 1

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PENNSYLVANIA MEDICINE, established in 1897, is published monthly as the official publication of the Pennsylvania Medical Society. All original papers and correspondence should be directed to the Managing Editor. Subscription requests and changes of address should be sent to PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043. A subscription is $5.00 per year. Single issues are 50 cents. Second class postage is paid at Lemoyne, Pennsylvania 17043.

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FEB 5 1975

BOARD OF TRUSTEES ACTS ON MALPRACTICE INSURANCE CRISIS

The State Society's Board of Trustees at its January 15, 1975 meeting appointed an ad hoc committee to devote as much continuous time as is necessary to studying the medical malpractice crisis and possible solutions. The committee is to report its findings and recommend a package of proposals to the Board of Trustees when it meets March 12 and is to report in writing to the trustees periodically in the interim.

Members of the ad hoc committee are the following Society officials: A. Reynolds Crane, M.D., president; David S. Masland, M.D., president elect; Donald E. Harrop, M.D., chairman of the Council on Governmental Relations and of the Commission on Forensic Medicine; and John J. Danyo, M.D., chairman of the Commission on Professional Liability Insurance.

The Board also voted to refer the report of the Commission on Forensic Medicine to the ad hoc committee. The report outlined legislative and judicial action which is being considered or has been taken by other states in dealing with the malpractice crisis which is nationwide.

The Board's action followed a letter dated January 9 from President Crane to all Society members explaining the background of the crisis and its impact on the Society's written agreement with Frank B. Hall of Pennsylvania, Inc., and Argonaut Insurance Co. At the time the Board of Trustees was meeting, Society officers met with officials of Argonaut to review the professional liability insurance agreement. Argonaut officials will meet again by January 22 with Society officers and be prepared at that time to submit specific proposals on the company's future intentions for Society consideration.

The national scope of the malpractice insurance crisis was recognized last week by Secretary of Health, Education, and Welfare

Caspar W. Weinberger, who told an audience of insurance company representatives and state insurance commissioners that the federal government is considering emergency legislation to guarantee federal reinsurance for consortiums of private insurance companies if they experienced unusually heavy losses.

In Pennsylvania, Insurance Commissioner William J. Sheppard in the January 11, 1975 Pennsylvania Bulletin called on writers of professional liability insurance to submit to his department by January 30, 1975 the following data: 1. Classes of physicians, surgeons, dentists, hospitals, and others insured or reinsured in the Commonwealth; 2. Restrictions on writing, either taken or contemplated; 3. Reason for such restrictions; 4. Suggestions for legislative alleviation of the cause for restrictions.

Pennsylvania physicians are protected in the event an insuring company becomes insolvent by the Pennsylvania Insurance Guarantee Association Act--Act 232 of 1970. The act provides that all insurers in Pennsylvania dealing in the casualty lines of business contribute to a fund at a specified rate to provide for the payment of covered claims in the event of the insolvency of one of the companies.

Approximately 4,000 Pennsylvania physicians are covered by professional liability insurance by Argonaut; some 6,000 by Medical Protective Co; about 1,200 by Aetna; and the balance by a number of companies doing limited amounts of business in the Commonwealth.

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Before prescribing, please consult complete product information, a summary of which follows:

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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Nicotinic Acid .....100 mg.	Nicotinic Acid .....250 mg.	Nicotinic Acid .....300 mg.
Niacinamide ..... 75 mg.	Niacinamide ..... 75 mg.	Ascorbic Acid .....150 mg.
Ascorbic Acid .....150 mg.	Ascorbic Acid .....150 mg.	Thiamine HCL (B-1) .... 25 mg.
Thiamine HCL (B-1) .... 25 mg.	Thiamine HCL (B-1) .... 25 mg.	Riboflavin (B-2) ..... 2 mg.
Riboflavin (B-2) ..... 2 mg.	Riboflavin (B-2) ..... 2 mg.	Pyridoxine HCL (B-6) ... 10 mg.
Pyridoxine HCL (B-6) ... 10 mg.	Pyridoxine HCL (B-6) ... 10 mg.	**DOSE:** 1 to 3 tablets daily.
DOSE: 1 to 5 tablets daily.	**DOSE:** 1 to 3 tablets daily.	**AVAILABLE:** Bottles of 100, 500, 1000
AVAILABLE: Bottles of 100, 500, 1000	**AVAILABLE:** Bottles of 100, 500, 1000	

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

WRITE FOR LITERATURE AND SAMPLES

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The Cooperative, which will effect its savings by purchasing in large volume directly from the manufacturer and reselling to the physician at cost, will limit itself to expendable supplies in the initial phase of its operation only. Later when it expands its inventory to include more costly items such as surgical supplies and office equipment, the potential for savings will be even greater.

Membership in the Cooperative will be open to Pennsylvania Medical Society members only. The only cost is a nominal $100 once-and-done lifetime membership fee, all or a substantial part of which will be returned if you should decide to withdraw. In all probability you will save more than the amount of the membership fee in your first-year purchases alone.

However, dollar savings are not the only benefit. The Cooperative's system of blanket contracts and automatic shipments will do much to simplify your purchasing procedures and reduce the burden of inventory control.

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Another New Benefit to Members of Pennsylvania Medical Society

Dr. Sodeman candidate for AMA president elect

William A. Sodeman, M.D., of Toledo, Ohio, will seek election to the office of president elect of the American Medical Association at the June 1975 annual meeting in Atlantic City, N. J.

The Pennsylvania Delegation to the AMA in a letter to all AMA delegates and alternate delegates January 6 announced its intention to nominate Dr. Sodeman, a native of Charleroi, Pennsylvania.

Although Dr. Sodeman now serves as Clinical professor of medicine at Medical College of Ohio at Toledo, he has continued his membership in the Philadelphia County and Pennsylvania Medical Societies. He served as dean and vice president of Jefferson Medical College in Philadelphia from 1958 to 1967 and holds the title of dean emeritus and professor of medicine emeritus of that institution. More recently he was executive director of the Commission on Foreign Medical Graduates, a position he held from March 1, 1970 to September 30, 1973.

Dr. Sodeman is board certified in internal medicine, cardiology, and preventive medicine and has served as consultant to the U.S. Public Health Service and the National Institutes of Health. He served for ten years on the AMA's Council on Medical Education and was its chairman for four years. He helped to establish the Committee, later to become the Council, on Health Manpower for the AMA.

DR. SODEMAN

Dr. Sodeman is a past president of both the American College of Physicians and the American College of Cardiology. He served as ACP treasurer for six years and was a member of the Finance Committee of the American College of Cardiology.

In its letter announcing intent to nominate, the Pennsylvania Delegation to the AMA said of him; "He has demonstrated outstanding leadership ability and throughout his professional life accepted the challenge of difficult assignments and has successfully guided organizations with complex problems through troubled waters. . .the leadership capability of this respected medical statesman, already tested by the Association and found to be outstanding, should now be applied to the appropriate office—president elect."

Dr . Sodeman completed his undergraduate education and received his degree in medicine at the University of Michigan, Ann Arbor. He is a member of numerous scientific and research organizations and author of 208 articles which have been published in the medical literature as well as of the monograph "Pathologic Physiology," which is currently being translated into five additional foreign languages.

WILLIAM Y. RIAL, M.D., SWARTHMORE, VICE SPEAKER OF THE AMA HOUSE OF DELEGATES AND RUSSELL B. ROTH, M.D., ERIE, AMA PAST PRESIDENT

AMA DELEGATION CAUCUSES AT PORTLAND MEETING

April 23-24 reserved

Donaldson memorial lecture highlights 1975 conference

The first Walter F. Donaldson Memorial Lecture will highlight the 1975 Officers' Conference scheduled for April 23 and 24 at the Host Inn, Harrisburg. Invitations will be sent at the end of January to county society officers. The conference will open at 1 p.m., Wednesday, April 23 and conclude at noon on Thursday, April 24, R. William Alexander, M.D., of Reading, chairman of the Officers' Conference Committee, said.

For Wednesday evening, the committee has planned a banquet and entertainment. Sessions on both days will be devoted to current issues of special concern to the medical community.

The memorial lecture honoring Dr. Donaldson was established by the Board of Trustees to bring distinguished speakers to the Society's annual gathering of county society officers and to honor Dr. Donaldson, who was Society president in 1917. Dr. Donaldson's distinguished career as a leader of organized medicine in the Commonwealth included serving as Society secretary from 1918 to 1943, secretary treasurer from 1943 to 1952, and editor of Pennsylvania Medical Journal (now PENNSYLVANIA MEDICINE) from 1940 until his death in September 1957.

Details on the Officers' Conference will appear in subsequent issues of PENNSYLVANIA MEDICINE.

Members of the Officers' Conference Committee are: Drs. J. Mostyn Davis, Shamokin; William E. DeMuth, Hershey; John P. Mraz, Erie; George R. Fisher, Philadelphia; Orlo G. McCoy, Board representative; A. Reynolds Crane, Society president, and Dr. Alexander.

Hahnemann, Gannon launch fp training program

Letters of intent to launch a program to train family physicians for medically deprived areas of the Commonwealth were signed December 6, 1974 by the presidents of Gannon College, Erie, and Hahnemann Medical College and Hospital.

The program will become operable in September 1975 when some 100 first year premedical students begin their studies at Gannon College. Of this number, about twenty will continue to pursue their studies in medicine at Hahnemann in September 1977. They will be chosen on the basis of academic performance and personality screening. They will return to Erie in the spring of 1980 to study family medicine with physicians and at health care institutions in the area.

Students completing the six year track in the spring of 1981 will receive a bachelor of science degree from Gannon and the degree of doctor of medicine from Hahnemann.

A similar affiliation between Wilkes College and Hahnemann was initiated over two years ago.

Approval of the Erie program was recommended in a feasibility report prepared by a committee which included representatives of Gannon, Hahnemann, and the medical profession, health care institutions, state and federal lawmakers, and community associations of the Erie area. A year and a half of planning and study preceded the formal signing of the letters of intent. Government funding for the program is being sought.

Planning evaluation committee completed

Membership on the Society's ad hoc committee to evaluate planning has been completed with the appointment of two additional members by Cyrus B. Slease, M.D., chairman of the Board of Trustees.

Donald R. Cooper, M.D., of Philadelphia, and Robert S. Sanford, M.D., of Mansfield, will serve on the committee, bringing its number to five. The committee was established by the Board of Trustees last August to review the structure for Society planning and the accomplishments of past planning activity. Originally appointed to the committee were Kenneth L. Cooper, M.D., Williamsport; David J. Keck, M.D., Fairview; and Orlo G. McCoy, M.D., Canton. Dr. Keck serves as chairman.

Dr. Rosemond ACS head

New national president of the American Cancer Society (ACS) is George P. Rosemond, M.D., Philadelphia surgeon. During the past year he served ACS as vice president.

Dr. Rosemond is a professor of surgery at Temple University School of Medicine and served as chairman of the department and division of surgery at Temple University Health Services Center from 1960-1973. He is a past president of the Pennsylvania Medical Society and of the Philadelphia Academy of Surgery.

Norman J. Skversky, M.D., of Philadelphia, whose article, "Medical treatment of thrombophlebitis and pulmonary embolism," appeared in the December 1974 issue of PENNSYLVANIA MEDICINE, wishes to acknowledge the co-authorship of L. Andre Corman, M.D.

Dr. Watson speaks out

Cooperative enters final weeks of charter member drive

With its charter membership drive now entering the final few weeks, the Pennsylvania Medical Cooperative still needs 700 physician members in order to open its doors for business.

"I personally find it hard to believe there aren't 2,000 physicians in Pennsylvania interested in saving money," said Dr. Ulysses E. Watson, chairman of the Council on Professional Relations and Services.

"Maybe physicians are taking a wait-and-see attitude," said Dr. Watson. "If that's the case, they may wait too long. If we do get the members we need, and I think that's a real possibility, that waiting will cost them another $100. February 1 the Co-op membership fee jumps to $200.

"If we don't get the 2,000 members we need by the end of this month, then that's it. The Cooperative is dead, and so are the chances for physicians to save money on their supplies.

"I'm not talking about saving $5 or $10 either. I'm talking about hundreds of dollars in savings every year. And we're not pulling those figures out of the air," Dr. Watson emphasized.

A marketing study to determine the feasibility of a physicians' cooperative was performed prior to the membership drive. That study showed that on the twenty or so expendable items the Co-op will offer at the start, the average physician now spends $600 per year. It also showed that with the use of a cooperative, physicians could save 30 to 50 percent on those supplies.

"Anyone who takes a moment and multiplies 30 percent by $600 will soon see that the $180 in projected savings is a pretty good

return for a $100 investment," said Dr. Watson.

"And you're investing in an enterprise that's going to grow and expand. The goal is to make the Co-op a full service organization. It's going to offer everything from stethoscopes to surgical equipment to electrocardiograph machines. You name it, and the Co-op will eventually sell it. And I really mean you name it, because it will be the physician-members who determine what products their cooperative will sell—and sell at substantial savings."

L. Riegel Haas, the Society's director of professional relations, personally has travelled more than 9,000 miles in the past ten months telling physicians about the Cooperative. When he tells them about the savings potential, the reaction is sometimes disbelief.

"Many physicians believe they are already paying the lowest possible price for the disposable supplies, or at least close to it," said Haas. "But when they've done some closer checking, some of them have found a few surprises.

"One physician found that he could buy the same paper products at his local grocery store for one-third of the price that he was paying his supplier. Another physician found his patients were paying less for adhesive bandages at the local drugstore than he was getting them for from his supplier."

Physicians could probably save money simply by doing some comparison shopping. "The fact is, that's basically what the Cooperative will do, but on a much larger scale with the potential for much greater savings," said Haas. "The Cooperative will go directly to the various manu-

As an extra incentive to join now, the Pennsylvania Medical Cooperative is offering some prizes.

Grand prize, courtesy of the Lehigh County Medical Society and Intrav, is a deluxe, all expense paid, two week trip for two to the British Isles and Holland.

Second prize is $500 worth of free medical supplies from the Co-op.

Other prizes include two $250, three $100, and ten $50 awards of Co-op supplies.

Medical supply prizes are based on Co-op prices—which means their actual dollar value will be 30 to 50 percent higher, since that's the kind of saving the Co-op will offer. Winners will be drawn from the names of all charter members following the close of the membership drive, January 31. All prizes are contingent on the Co-op reaching its goal of 2,000 subscriptions.

facturers and will say 'Look, we represent several thousand Pennsylvania physicians. We're their purchasing agent. Now, what's your best price?' Then the Cooperative can pass those savings on to its members."

Will dealing with manufacturers directly put the middle men out of business?

"It certainly is going to have an effect on how they operate. They're going to have to make themselves more competitive. But the Cooperative certainly won't drive them out of business," said Haas.

"Those physicians who worry that their suppliers will get mad and not sell them supplies not carried by the Co-op at the start aren't really looking at things realistically," adds Dr. Watson. "The supplier certainly isn't going to stop selling you one product because you buy another from somebody else. He's interested in making money; and if he refuses to sell you supplies, he doesn't make any money.

"Physicians get pushed around by government, they're pressured by consumers, and they're forced to pay the going price in the marketplace when buying supplies," said Dr. Watson. "PMS is fighting to protect their interests in government. We're working to improve their public image. Now the Society is offering a chance for physicians to make their weight felt in the marketplace too. That chance, however, ends on January 31. Physicians now have a choice. They can pay their $100 and join the Cooperative now, or they can go on paying indefinitely."

Nursing statistics show need for more

Pennsylvania schools of nursing graduated 4,115 registered nurses in 1974, 325 more than in 1973, but 463 fewer than Department of Education statistics show are needed "for growth and replacement." This information was released by the Hospital Association of Pennsylvania, which began a "Be a Nurse" campaign in 1970.

Figures for 1974 also showed that 5,586 students enrolled as freshmen in the schools of nursing, 358 fewer than in 1973.

There are sixty-one hospital schools of nursing in the Commonwealth, and in September 1974 there were only 100 empty seats in their classrooms, as contrasted with 874 vacant seats in 1970 before the "Be a Nurse" campaign began.

Please enroll me as a charter member of the Pennsylvania Medical Cooperative. Bill me in the amount of $100 to cover the membership requirement. It is my understanding that this is a one-time subscription entitling me to a vote in the affairs of the Cooperative plus giving me the right to purchase all medical supplies offered by the Cooperative.

NAME: _____

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HEW publishes utilization review regulations

On February 1, 1975, regulations governing utilization review procedures applicable to patients admitted to hospitals under medicare and medicaid programs will become effective.

The Department of Health, Education, and Welfare (HEW) published the final regulations on November 29, 1974. They were developed from a proposal made January 9, 1974, which drew over 4,700 comments from interested parties. As now formulated, the regulations call for the review of admissions within one working day of each admission.

For use until PSRO

Although not related to the Professional Standards Review Organization (PSRO) law, the new rules will govern utilization review procedures until the PSRO system becomes operational. Although planned for use beginning January 1, 1976, PSRO may take as long as two more years to implement, according to HEW. Introductory comments to the regulations maintain that they will assist the development of PSROs and enable them "to concentrate their efforts on relatively smaller areas of questionable professional activities."

The new regulations are separated into two parts: (1) conditions of participation for hospitals and nursing facilities under medicare; and (2) utilization control of care and services under state-administered medicaid plans. Documentation will be required to support the admission to a hospital of a medicare or medicaid patient. Hospital review committees will require the following: (1) identification of the eligible individual and physician; (2) date of admission; (3) the physician's plan of care, which will be reviewed periodically and evaluated "by a physician and other personnel involved in the care of the eligible individual;" (4) where appropriate, the date of any operating room reservation; (5) in emergency admissions, the justification for such admissions; (6) the reasons for any continued stay and an appropriate plan of care; and (7) such other supporting material as the review committee deems appropriate.

Use own criteria

According to the rules, each admission will be evaluated against established criteria either developed by or selected by the institution's utilization review committee. Appropriate regional norms may be used where available to evaluate the necessity for extended stay and the plan of care.

The rules grant hospitals the authority to exercise preadmission review of an elective admission in those categories of admissions which produce unusually high costs or which have been found to be of questionable necessity.

Physician review provided

Admissions are to be reviewed within one day by the committee or a subgroup or designee of the committee. Admission screening might be done by nonphysician personnel, but where the admission is found unnecessary, the admitting physician will be afforded an opportunity to present his views. If he provides additional information, the admission will be reviewed by at least two other physicians. In the case of disallowed admissions, notices must be sent to the interested parties. In the case of allowed admission, a date for continuing review is set based upon the projected discard date. A decision on continuing hospital stays must be made within two days after the assigned review date.

Although the rules emphasize concurrent review, certain post-payment review procedures are authorized. For example, medicaid plans are required to establish "a post-payment review process that allows for the development and review of recipient utilization profiles, provider service profiles, and exceptions criteria. . .in order to rectify misutilization practices of recipients, providers, and institutions."

Children's clinic moved

The Pennsylvania Department of Health recently announced the relocation of the children's cardiac clinic from Polyclinic Hospital, Harrisburg, to the State Hospital for Crippled Children in Elizabethtown. The clinic will be staffed by physicians from the Hershey Medical Center and inpatient procedures will be handled at the Hershey Medical Center. Physicians wishing patients to be seen at this clinic should call the State Health Center, Harrisburg (717-787-8092) for an appointment.

Since the 1940s the Pennsylvania Department of Health has maintained the children's cardiac program throughout the Commonwealth. The program includes clinics where preliminary diagnostic studies are done and cooperating medical centers where complete diagnostic procedures and cardiac surgery are performed. It is supported by Federal Title V Crippled Children's funds.

LIFESAVING PARTNERSHIP... AGAINST CANCER QUACKERY

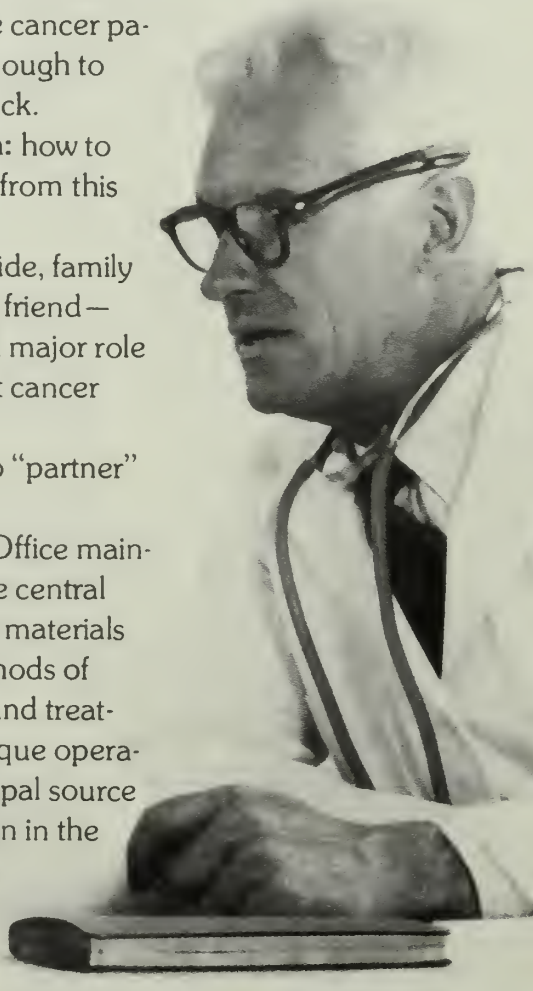
The anguish associated with cancer is compounded by the cancer quack. False hopes—harmful delays—shattering expenses—deceptive diagnoses—loss of life—these are hazards facing the cancer patient desperate enough to seek a cancer quack.

The problem: how to divert the patient from this tragic encounter.

As medical guide, family counselor, trusted friend—you, doctor, play a major role in the fight against cancer quackery.

We are here to "partner" you.

Our National Office maintains an up-to-date central clearing house for materials on unproven methods of cancer diagnosis and treatment. This is a unique operation and the principal source of such information in the country. Its services are widely used. Hundreds of inquiries are received and answered from all segments of the community, from coast to coast.



To trigger grass-roots action, we have formulated a model State Cancer Remedy Act designed to control the promotion and sale of unproven methods of cancer management. This has already inspired nine states to legislate against cancer quackery—with active support from the medical community. Copies of the model act, as well as copies of the laws in effect, are available in our National and Division offices.

In these actions against cancer quackery, as in all our efforts against cancer, ours is a lifesaving partnership.

American Cancer Society

THIS SPACE CONTRIBUTED BY THE PUBLISHER

Bicentennial birthday present

Physicians organize to preserve Benjamin Rush House

ROBERT E. JONES, M.D.
Philadelphia

The Pennsylvania Medical Society has adopted as its official project for the 1976 American Bicentennial the preservation of the birthplace of Dr. Benjamin Rush, signer of the Declaration of Independence and pioneer in American psychiatry. The Society will join with the Benjamin Rush House Committee, a group of physicians, educators, and civic leaders, and the American Psychiatric Association to raise funds for the restoration of the birthplace of Pennsylvania's most famous native physician, the "father of American medicine."

BIRTHPLACE OF BENJAMIN RUSH

Rush state park proposed

A proposal to create Benjamin Rush State Park from a 275-acre section of the grounds of Philadelphia State Hospital has been introduced in the Legislature. Support for this part of the overall project is needed from all physicians if it is to be successful.

The Commonwealth has already granted permission to erect the Rush House on the grounds of Philadelphia State Hospital along Route 1—Roosevelt Boulevard—the busy northeast gateway to Philadelphia. There the house, one of America's most important medical shrines, will serve as a welcome center for Philadelphia, a community meeting place and an educational landmark. The Commonwealth has agreed to maintain the house in perpetuity.

The Rush birthplace

Rush was born on Christmas Eve, 1745, in the modest stone farmhouse built by his great-grandfather, John Rush, who had fought under Cromwell and arrived in Pennsylvania in 1683.

Until recently the Rush house was the only existing home of a signer of the Declaration of Independence. Through a tragic error the building was razed in 1969 when an apartment complex was being built on the Rush homestead. A group of concerned citizens then formed the Benjamin Rush House Committee and transferred the stones and woodwork to the grounds of Philadelphia State Hospital where they are in safekeeping awaiting re-erection.

Distinguished citizens across the nation, including representatives of all the organizations with which Rush was associated, have offered to serve as honorary patrons of the committee. Among them are the presidents of Princeton University, the University of Pennsylvania, Dickinson College and Franklin and Marshall College. Physicians are represented by the presidents and past presidents of the American Medical Association, Pennsylvania Medical Society, and the American Psychiatric Association. Other eminent patrons of the project are Drs. Karl Menninger and Jonas Salk, Governor Milton J. Shapp and Senators Hugh Scott and Richard S. Schweiker.

The local citizenry has also taken part in the reconstruction of the Rush home. The Northeast Philadelphia Chamber of Commerce has made it one of their Bicentennial projects. Colonial panelling has been purchased by the Benjamin Rush House Committee to supplement the damaged woodwork. School children have helped to raise money for a new front door and women's clubs are giving fund-raising benefits.

Rush's accomplishments

Although five signers of the Declaration are known to have practiced medicine, Rush was the only signer with a medical degree. After graduation from Princeton at age fifteen, he obtained his medical diploma at the University of Edinburgh and

BENJAMIN RUSH AT AGE 50

began a lifetime practice in Philadelphia.

Rush's medical accomplishments alone place him among the giants of American medicine. He became the first professor of chemistry at the nation's first medical school, the University of Pennsylvania, and wrote the first textbook of chemistry in America. He served as physician to Pennsylvania Hospital for thirty years and became the hero of the yellow fever epidemics of the 1790s. He founded the first free medical clinic for the relief of the poor. He was a founder of the College of Physicians of Philadelphia. Because he published the first book on mental illness in America in 1812, he is known as the "father of American psychiatry," and his profile is in the seal of the American Psychiatric Association. He is likewise hailed as "patron saint" by obstetricians, pediatricians, veterinarians and tuberculosis specialists, as well as by those in military medicine. He was the most esteemed medical teacher of the eighteenth century and the first American physician to gain an international reputation.

Rush as patriot, humanitarian

A friend of Adams, Jefferson, Franklin, and Washington, Rush stands among the greatest patriots of Revolutionary times. He gave the name, *Common Sense,* to Thomas Paine's fiery pamphlet and he was the second youngest signer of the Declaration. "No form of government can be rational but that which is derived from the Suffrages of the people who are the subjects of it," he said. Washington relied on his advice prior to the battles of Trenton and Princeton after Rush had become physician-general to the Continental Army. In more peaceful times, Rush became treasurer of the United States Mint under President Adams. He even proposed to install a Secretary of Peace in the president's cabinet.

After he had helped bring about changes in the nation's political structure, he was not content until he effected several sociological changes as well. He explained, "The American war is over, but that is far from being the case with the American Revolution."

Of all the founding fathers of the nation, Rush was the greatest promoter of health, education, and welfare. With Benjamin Franklin, Rush founded, in 1774, the first organization in America for the abolition of slavery. He staunchly supported the freedom, education, and religious instruction of Black Americans. He was a promoter of public schools, helped found Dickinson College and was a founding trustee of Franklin and Marshall College.

Rush was also a founder of the Pennsylvania Prison Society. He urged prison reform, rehabilitation of criminals and abolition of the death penalty.

Send contributions

Forty national and local patriotic and medical organizations are sponsoring the Benjamin Rush House Committee. Officers are Dr. Robert Jones, chairman, Dr. Daniel Blain, vice chairman, and Townsend Munson, treasurer. Dr. Blain is past president of the American Psychiatric Association.

Letters will be mailed to all members of the Pennsylvania Medical Society requesting that contributions be made to the restoration project with a minimum of $10. There is no maximum limit.

Tax-deductible contributions may be sent to the Benjamin Rush House Committee, 111 North 49th Street, Philadelphia, Pa. 19139.

Brief law—big impact

Peer review protection act does what title says

Proposed health care legislation set records on the state level in 1973-74, and Society officers and the Council on Governmental Relations studied and guided Society action on a record number of bills, many of which died when the Legislature adjourned *sine die* on November 30, 1974.

The State Society caused to have introduced and saw through to its enactment one bill which will have a profound effect on peer review activities in the Commonwealth. Peer review came under official state protection on July 20, 1974 when Governor Milton J. Shapp signed into law H.B. 1729, "The Peer Review Protection Act," and it became Act 193 of 1974.

While the enactment of the law and its provisions were reported at the time, its full import may not have been realized because so much proposed legislation concerning health care delivery was under consideration simultaneously.

Essentially the law protects members of review committees and persons who give them information. It protects the confidentiality of the records of review organizations and committees. The records must be held in confidence and are not subject to discovery or introduction into evidence in any civil action arising out of review activities.

Persons attending a peer review meeting are not permitted to testify in any civil action as to what transpired in the meeting. This does not mean that original documents, such as medical records, are exempt from discovery and introduction into court. Nor does it mean that physicians are exempt from litigation or testimony regarding hospital medical records. Doctors are, however, exempt from testifying about peer review committee discussions and conclusions.

The Act is very broad, covering all health care professionals who are licensed under the laws of the Commonwealth, including doctors, dentists, nurses, podiatrists, etc.

Peer review is defined as "the procedure for evaluation by health care professionals of the quality and efficiency of services ordered or performed by other health care professionals, including practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review, and claims review." The new Act also protects county medical societies and the state medical society as long as they have "as members at least a majority of the eligible licentiates in the area."

The list of "review organizations" covered is long. It includes "a hospital utilization review committee, a hospital tissue committee, a health insurance review committee, a hospital plan corporation review committee, a professional health service plan review committee, a dental review committee, a physician's advisory committee, a nursing advisory committee, any committee established pursuant to the medical assistance program, and any committee established by one or more state or local professional societies." The law also protects hospital boards or committees reviewing the professional qualifications or activities of its medical staff or applicants for admission to medical staffs.

Activities of peer review committees which are protected by the law are: 1. Evaluating and improving the quality of health care rendered; 2. Reducing morbidity or mortality; and 3. Establishing and enforcing guidelines designed to keep within reasonable bounds the cost of health care. As peer review activities are increased, the importance of Act 193 of 1974 will be self evident.

Pennsylvanians elected

Two Pennsylvanians, Theodore A. Tristan, M.D., Harrisburg, and J. W. J. Carpender, M.D., Sayre, were elected to high offices at the annual meeting of the Radiological Society of North America.

Dr. Tristan was elected secretary of the national organization. He is president elect of the Pennsylvania Radiological Society and director of the division of radiology at Harrisburg Polyclinic Hospital.

Dr. Carpender was elected chairman of the board of directors. He is cochairman of the department of radiology and chief of radiation therapy and nuclear medicine at Robert Packer Hospital and Guthrie Clinic in Sayre. Dr. Carpender is a past president of the American Board of Radiology.

The Literature Search Program Reference Section of the National Library of Medicine has available a literature search on acupuncture which includes 181 citations from April 7, 1973 through April 1974. Physicians can receive single copies of this search at no cost. Indicate Acupuncture Literature Search No. 74-5 and address inquiries to Literature Search Program, Reference Section, Reference Services Division, National Library of Medicine, 8600 Rockville Pike, Bethesda, Md. 20014.

AMA/PMS dues, benefits detailed here

The PMS Benefits designated below as "all" include participation in or eligibility for:

Appointment to commissions, committees, and councils; election to office; the right to vote
Automobile Leasing Plan
Group insurance programs
PMS Professional Liability Insurance Program
Disability Income Plan
Exceptional Risk Disability Income Plan
Executive Major Medical Coverage
Excess Major Medical Coverage
Business Overhead Expense Plan
Accidental Death and Dismemberment Plan
Individual Life Insurance Program
Group Automobile Insurance Program
Group Life Insurance for Professional Corporations
Personal-Professional Umbrella Liability Insurance Program
Workman's Compensation Dividend Program
Medical Benevolence Fund
Educational Fund
Pennsylvania Medical Continuing Education Institute
Pennsylvania Medical Care Foundation
Legal opinions on medico-legal questions
Counsel on questions of medical ethics
Peer review on request in disputes involving third parties
Input on legislative matters through an effective lobby
PENNSYLVANIA MEDICINE
Physician Placement Service
PaMPAC
Speech writing service
Public Relations Counsel
Free Health Education pamphlets

There are other programs and services in addition to those listed.

Membership Classifications
PMS and AMA Dues Purposes

ACTIVE MEMBER - Any physician who is fully licensed to practice medicine and surgery in the Commonwealth of Pennsylvania and is a member of a component society. Also, any physician who is employed full-time by the federal government in a civilian or military capacity and does not hold an unrestricted license to practice medicine and surgery in the Commonwealth of Pennsylvania.

Dues: PMS - $150.00
AMA - $110.00 (AMA dues may be excused (1) by reason of financial hardship or illness, (2) if member is retired from active practice, or (3) over age 70.)

Benefits: PMS - All
AMA - All except publications for AMA dues exempt members are available only by subscription.

MILITARY- (ACTIVE MEMBER) - Any active member serving *temporarily* in the armed forces or other federal government service (before March 1).

Dues: PMS and AMA - Dues exempt
Benefits: PMS - All
AMA - Same as AMA dues exempt above.

DISABILITY - (ACTIVE MEMBER) - Any Active Member who is prevented from the practice of medicine by reason of illness or disability.

Dues: PMS and AMA - Dues-exempt
Benefits: PMS - All
AMA - Same as AMA dues exempt above.

INTERN AND RESIDENT - Any Member serving a hospital internship, residency, or other recognized full-time postgraduate training.

Dues: PMS - $15.00 (10% of regular assessment)
AMA - $20.00
Benefits: PMS - All
AMA - All

SENIOR ACTIVE MEMBER - Any member at least 65 years of age on January 1 with at least 30 years continuous membership (membership in other states or AMA may be included).

Dues: PMS - $75.00 (50% of regular assessment)
AMA - $110.00 (AMA dues may be excused (1) by reason of financial hardship or illness, or (2) if member is retired from active practice or (3) over age 70).
Benefits: PMS - All
AMA - Same as Active Member except publications for AMA dues exempt under (1), (2) or (3) are available only by subscription.

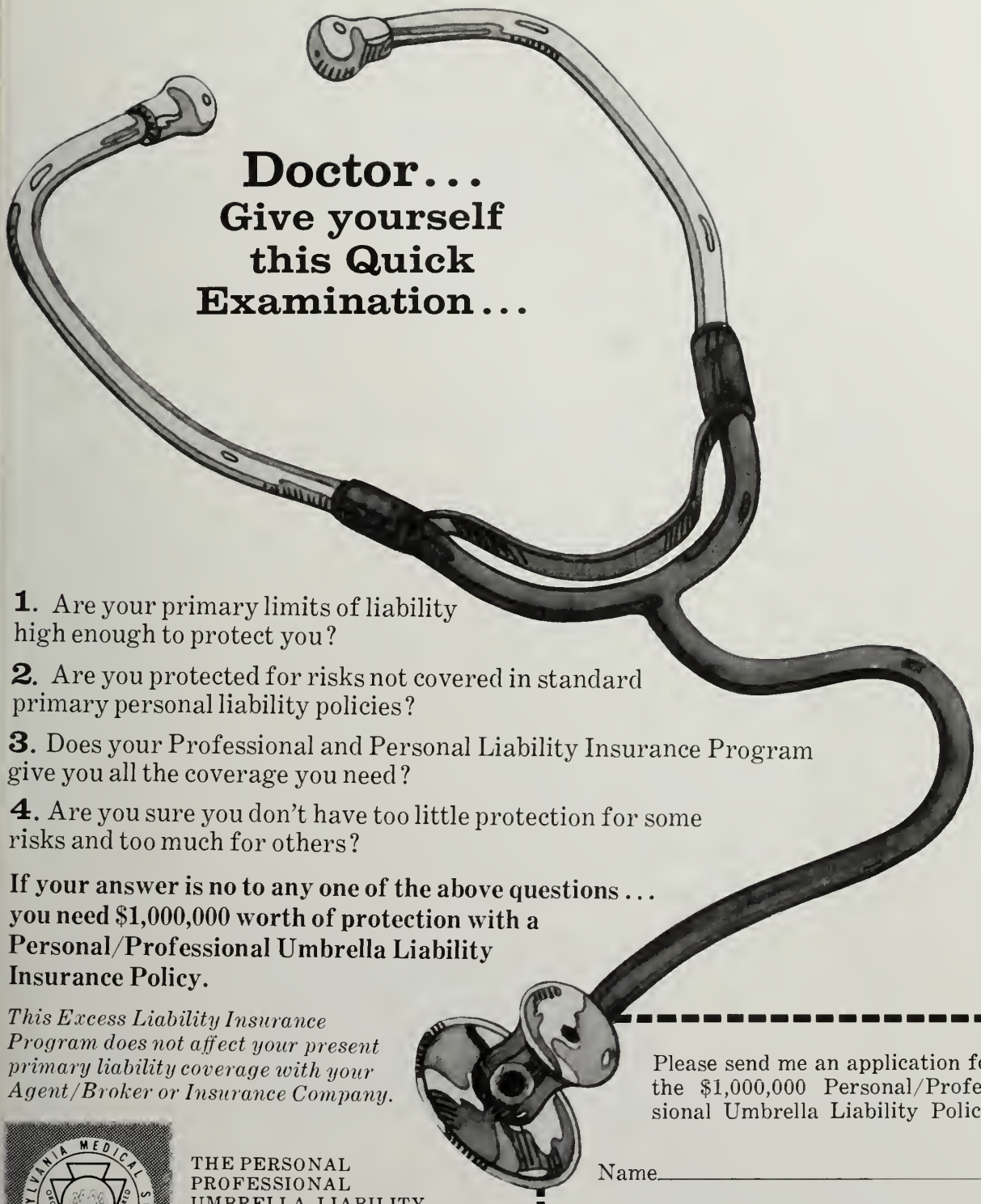
ASSOCIATE MEMBER - Any Active or Senior Active Member who is at least 70 years of age and who has at least 30 years continuous membership (membership in other states or AMA may be included).

Dues: PMS and AMA - Dues-exempt
Benefits: PMS - All—except cannot vote, hold any office, serve as delegate, member of commission, committee or council.
AMA - May not vote or hold office and will not receive scientific publications except by direct subscription.

AFFILIATE MEMBER - Any member of a component society who belongs to one of the following classes:

(a) members of national medical societies of foreign countries
(b) American physicians whether or not licensed to practice medicine and surgery in Pennsylvania engaged in missionary or philanthropic labors
(c) full-time teachers of medicine or of the arts and sciences allied to medicine who are not holders of an unrestricted license to practice medicine and surgery in the Commonwealth of Pennsylvania
(d) physicians not fully licensed to practice medicine in Pennsylvania who are engaged in Pennsylvania in research, public health or administrative medicine
(e) physicians, whether or not fully licensed to practice medicine in Pennsylvania, who are retired from active practice
(f) physicians in active practice who move out of the Commonwealth of Pennsylvania if they maintain active membership in a county society and the state society in their new state of residence. Members in this category are not eligible for any Society-endorsed insurance programs.

Dues: PMS and AMA - Dues-exempt
Benefits: PMS - cannot vote or hold any office, serve as a delegate, member of a commission, committee, or council, and is not entitled to benefits of Medical Benevolence Fund or Educational Fund
AMA - Same as Associate Member



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Precautions: As with other thyroid preparations, an overdosage of SYNTHROID (sodium levothyroxine) may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, such as Addison's Disease (chronic adrenocortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development o chest pains or other aggravations of cardiovas cular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocar dial infarction. **Side effects:** The effects of SYN THROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

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1 *Synthroid* is T_4.

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3 T_4 hormone content is controlled by chemical assay.

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1. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T_4) to Triiodothyronine (T_3) in Athyreotic Human Subjects, J. Clin. Invest. *49*:855-64, 1970.
2. Surks, M. I., Schadlow, A. R., and Oppenheimer, J. H.: A New Radioimmunoassay for Plasma L-Triiodothyronine: Measurements in Thyroid Disease and in Patients Maintained on Hormonal Replacement. J. Clin. Invest. *51*:3104-13, 1972.

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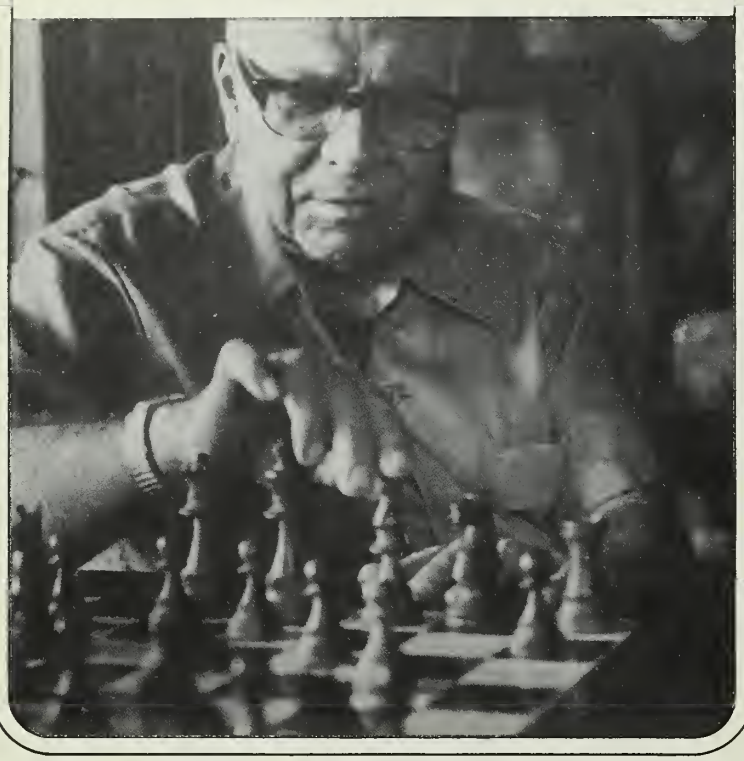

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Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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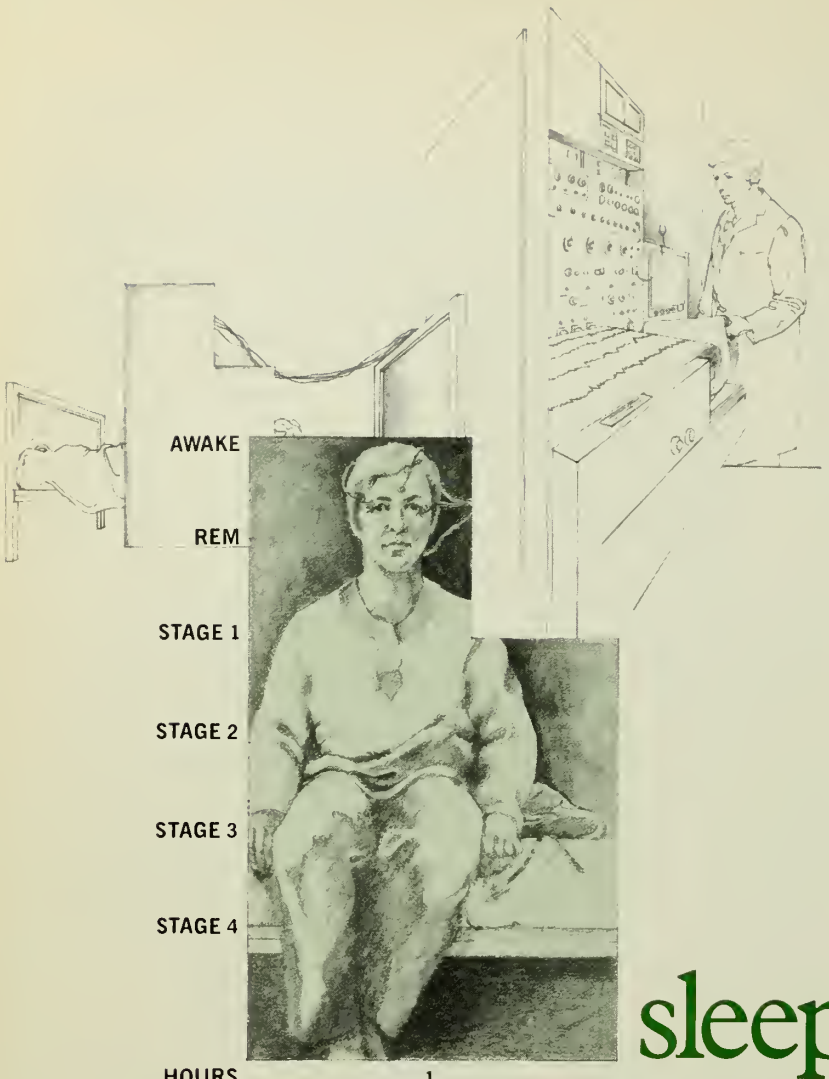
TO KEEP BLOOD PRESSURE DOWN AND KEEP POTASSIUM LEVELS UP



sleep begins within 17 minutes, on average ...

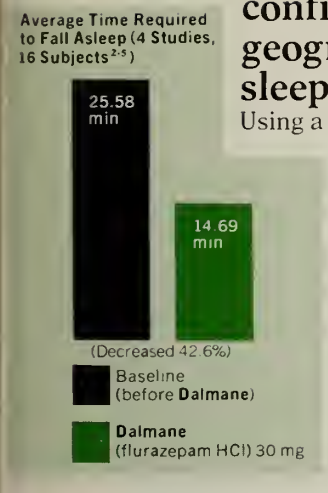
an initial benefit of

Dalmane®

(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]


Average Time Required to Fall Asleep (4 Studies, 16 Subjects[2-5])
25.58 min
14.69 min
(Decreased 42.6%)
Baseline (before Dalmane)
Dalmane (flurazepam HCl) 30 mg

confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

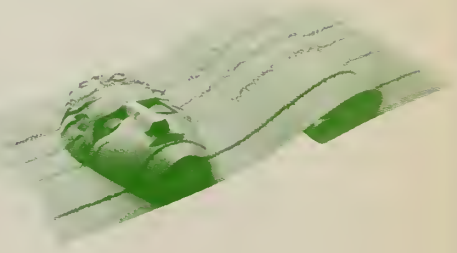
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- **induces sleep within 17 minutes, on average**
- **reduces nighttime awakenings**
- **sustains sleep 7 to 8 hours, on average, without repeating dosage**

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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When diarrhea has his number...

Lomotil puts him back in the game.

Physicians and patients both want prompt control of the symptoms of diarrhea. A rapid, uncontrolled loss of fluids and electrolytes can cause a medical crisis, particularly in children, and in patients who are seriously ill, or in people who are badly undernourished.

Lomotil usually stops diarrhea promptly. This rapid action halts the emergency aspect of diarrhea and is comforting and reassuring to the patient. Electrolyte and fluid losses can be corrected while the specific cause of the diarrhea is being determined. If an infective agent is the cause, appropriate antibiotic therapy should be given along with Lomotil.

Lomotil has few side effects, and those that do occur are generally mild.

Lomotil®
TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride ..... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate ..... 0.025 mg.

Usually stops diarrhea promptly.

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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The Pain Phone

When a telephone prescription for pain relief is necessary or convenient, you can call in your order for Empirin Compound with Codeine in 45 of the 50 states† That includes No. 4, which provides a full grain of codeine for more intense, acute pain.

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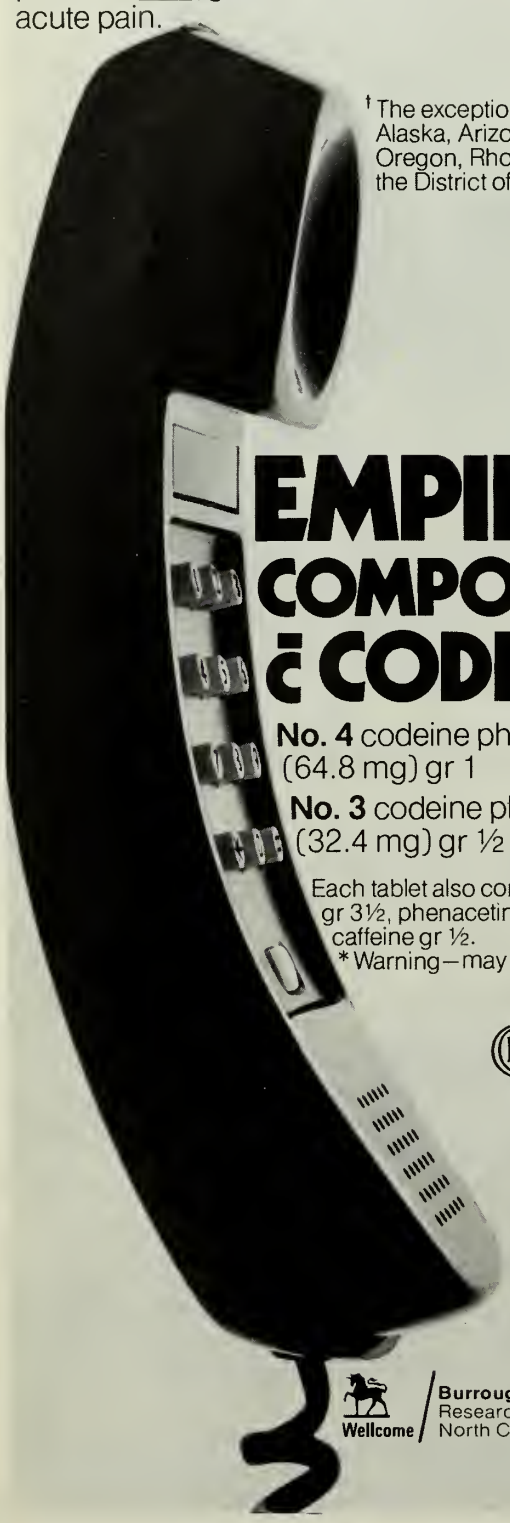

EMPIRIN® COMPOUND c CODEINE

No. 4 codeine phosphate* (64.8 mg) gr 1

No. 3 codeine phosphate* (32.4 mg) gr ½

Each tablet also contains aspirin gr 3½, phenacetin gr 2½, caffeine gr ½.

*Warning—may be habit-forming.

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High Blood Pressure

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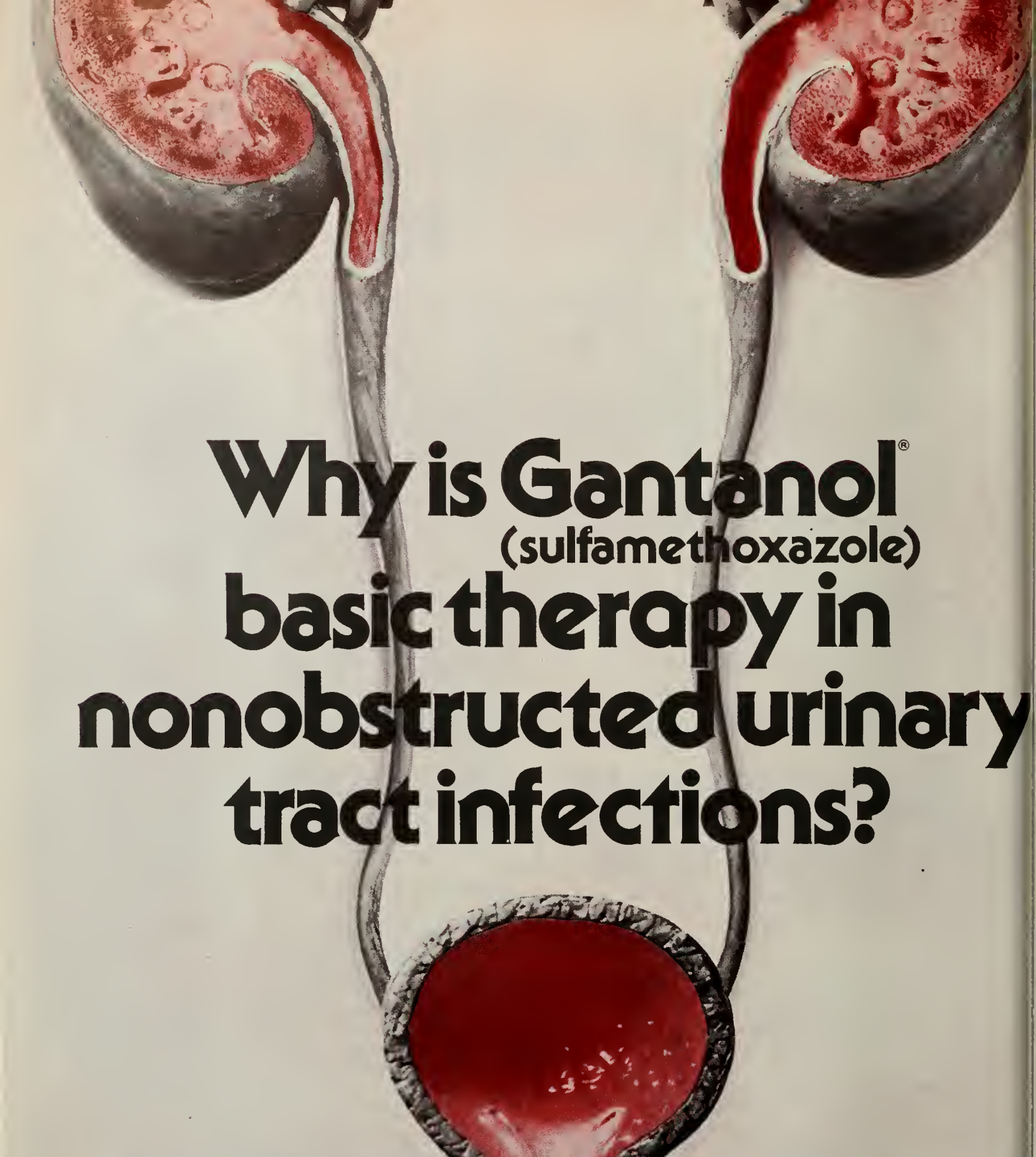


Why is Gantanol® (sulfamethoxazole) basic therapy in nonobstructed urinary tract infections?

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or pre vent sequelae (rheumatic fever, glomerulonephritis of such infections. Deaths from hypersensitivity reac tions, agranulocytosis, aplastic anemia and other bloo dyscrasias have been reported and early clinical signs (sor throat, fever, pallor, purpura or jaundice) may indicate seriou blood disorders. Frequent CBC and urinalysis with microscopi examination are recommended during sulfonamide therapy. Insuff cient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal c hepatic function, severe allergy, bronchial asthma; in glucose-6 phosphate dehydrogenase-deficient individuals in whom dose related hemolysis may occur. Maintain adequate fluid intake t prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplas tic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pur

Because it is considered a good choice...

- for efficacy in nonobstructed cystitis, pyelonephritis and pyelitis
- for control of susceptible *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*
- for prompt antibacterial blood and urine levels in from 2 to 3 hours after initial 2-gram adult dose
- for economical around-the-clock coverage
- for maximum patient cooperation with easy-to-remember B.I.D. dosage

Basic Therapy

Gantanol®

(sulfamethoxazole)

Tablets/Suspension (0.5 Gm) (0.5 Gm/teasp.)

pura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis): *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

MDs in the news

John P. Hubbard, M.D., has been installed as president of the College of Physicians of Philadelphia. He is immediate past president of the National Board of Medical Examiners. Other officers installed are: **John L. McClenahan, M.D.,** clinical associate professor of radiology at Jefferson Medical College, Thomas Jefferson University, vice president; and **Edward H. McGehee, M.D.,** professor of family medicine at Jefferson, secretary.

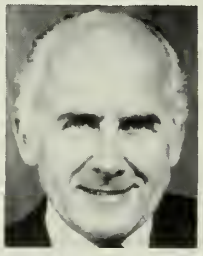
Yetta Deitch, M.D., retired physician, has opened a new geriatric clinic at the Penn Visiting Nurse Association in Ambler. Open two mornings a week, it offers free, complete physical checkups for patients 65 years of age and older who lack a private physician.

Medical College of Pennsylvania has announced the following recent faculty appointments: In the department of medicine: **Warren Katz, M.D.,** clinical professor and chief of rheumatology; **Stanley Nosheny, M.D.,** clinical assistant professor; **Susan Bray, M.D.,** clinical instructor; **Jules Lacavaro, M.D.,** and **Chester Smialowicz, M.D.,** instructors. Other appointments include **Martin D. Plutzer, M.D.,** instructor in the department of psychiatry; and **Suresh C. Ghosh, M.D.,** clinical instructor in thoracic and cardiovascular surgery in the department of surgery. Promotions include **Anthony DiGiovanni, M.D.,** to assistant professor of anesthesiology; **Sariel G. G. Ablaza, M.D.,** clinical professor of thoracic and cardiovascular surgery; and **Manuel R. Estioko, M.D.,** clinical assistant professor of thoracic and cardiovascular surgery.

James G. Bassett, M.D., has been elected president of the Philadelphia Division of the American Cancer Society. He is professor of surgery at Medical College of Pennsylvania. **N. Henry Moss, M.D.,** Merion, has been named medical vice president to the division's board of directors. Newly elected board members include **Leonard I. Goldman, M.D.,** Elkins Park, and **Alton I. Sutnick, M.D.,** Philadelphia. **Katharine R. Sturgis, M.D.,** Wynnewood, has been named an honorary life member.

Gabriel Tucker, Jr., M.D., Philadelphia, has been elected president of the American Council of Otolaryngology. He is clinical professor of laryngology and bronchoescophagology and professional associate of Temple University Hospital's Chevalier Jackson Clinic.

DR. TUCKER



DR. MUSGRAVE

Ross H. Musgrave, M.D., Pittsburgh, has been installed as president of the American Society of Plastic and Reconstructive Surgeons. He is president of the medical Staff at Presbyterian University Hospital and past president of the Pittsburgh Academy of Medicine.

Anita J. Herbert, M.D., Bradford, has been named a diplomate by the American Board of Internal Medicine. She is president of the McKean County Medical Society.

Julius Mazer, M.D., Pittsburgh, has been promoted to professor of clinical radiology at the University of Pittsburgh Medical School. He recently directed a symposium on diagnostic ultrasound presented by Magee-Womens Hospital, Pittsburgh.

Victor Whitman, M.D., of Case Western Reserve University, Cleveland, Ohio, has been named chief of pediatric cardiology at the Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center, Hershey. He was formerly assistant professor of pediatrics at Case Western Reserve University's medical school and associate pediatrician at University Hospital in Cleveland.

Herbert R. Hawthorne, M.D., Philadelphia, was presented with an award by the Association of Veterans Administration Surgeons at the Miami, Florida, meeting of the American College of Surgeons recently. He is emeritus professor of surgery at the Hospital of the University of Pennsylvania School of Medicine and consultant in surgery at Graduate and Veterans Administration Hospitals.

The Pennsylvania Division of the American Cancer Society has elected three Pennsylvania physicians for three-year terms as directors-at-large. They are **J. Mostyn Davis, M.D.,** Shamokin; **E. P. Gigliotti, M.D.,** Punxsutawney; and **John W. Kreider, M.D.,** Hershey. Elected as honorary directors are **Samuel Harbison, M.D.,** and **David W. Clare, M.D.,** both of Pittsburgh; and **Robert F. Dickey, M.D.,** Danville.

Siamak A. Adibi, M.D., Ph.D., has been promoted to professor of medicine at the University of Pittsburgh School of Medicine. He is also head of the gastrointestinal and nutrition unit at Montefiore Hospital, Pittsburgh.

Richard H. Michaels, M.D., has been promoted to professor of pediatrics at the University of Pittsburgh School of Medicine. He is also on the senior medical staff at Children's Hospital of Pittsburgh and on the consulting staff at Magee Womens Hospital. He is a diplomate of the American Board of Pediatrics.

The Pittsburgh Committee for Employment of the Handicapped has named **Jane Phillips, M.D.,** as Pittsburgh physician-of-the-year. She is medical director of the D. T. Watson Home for Crippled Children.

George L. Jackson, M.D., director of nuclear medicine at Harrisburg Hospital, has been appointed chairman of the steering committee for the newly formed Pennsylvania chapter of the American College of Nuclear Medicine. He is one of the

twelve-member Board of Regents of the American College of Nuclear Physicians.

Luther W. Brady, M.D., professor and chairman of the department of radiation therapy and nuclear medicine at Hahnemann Medical College and Hospital, has been elected president of the Society of Chairmen of Academic Radiology Departments.

R. Barrett Noone, M.D., assistant professor of surgery at the University of Pennsylvania School of Medicine, has become head of the section on plastic surgery at Pennsylvania Hospital. He is certified by the American Board of Surgery and the American Board of Plastic Surgery.

DR. NOONE

DR. DeLAURENTIS

Dominic A. DeLaurentis, M.D., has been named director of the department of surgery at Pennsylvania Hospital to succeed Jonathan E. Rhoads, M.D. He has also been appointed professor of surgery at the University of Pennsylvania School of Medicine. He was previously an attending surgeon and professor of surgery at Hahnemann Medical College and Hospital. Dr. DeLaurentis is a diplomate of the American Board of Surgeons and the National Board of Examiners.

Jewell L. Osterholm, M.D., has been appointed professor of neurosurgery and chairman of the department at Jefferson Medical College, Thomas Jefferson University. He was previously director of the division of neurological surgery, program director of neurosurgical residencies, and director of the Spinal Cord Injury Center and Laboratories at Hahnemann Medical College and Hospital.

Adrian Copeland, M.D., chief of adolescent psychiatry at Thomas Jefferson University Hospital, has published a "Textbook of Adolescent Psychopathology and Treatment."

Laszlo Geder, M.D., has been appointed visiting professor of microbiology at Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center. He was formerly a staff member of the World Health Organization in Zaria, Nigeria, and head of the department of microbiology at Ahmadu Bello University. He is a member of the Society for General Microbiology in England and of the Hungarian Association of Microbiology.

Herman Beerman, M.D., emeritus professor of dermatology at the University of Pennsylvania School of Medicine, was awarded the Thomas Parran Award for outstanding service in the venereal disease control effort at the annual meeting of the American Venereal Disease Association recently. Dr. Beerman also received a citation from Governor Milton J. Shapp for his work as a member of the governor's venereal disease task force.

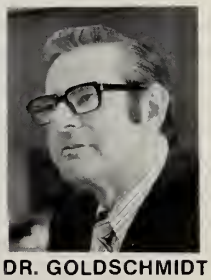
D. Lee Backenstose, M.D., Hershey, has been appointed regional chairman for the Four Diamonds Fund at the Milton S. Hershey Medical Center of Pennsylvania State University. The fund provides financial aid for medical care costs for families who have children suffering from Cancer. Dr. Backenstose is medical director of the Milton Hershey School and Hershey Estates and team physician for the Hershey Bears hockey team.

Eugene M. Sneff, M.D., Rutland, Vt., and **Americo B. Anton, M.D.**, have been named director and assistant director respectively of laboratory pathology at Altoona Hospital. Dr. Sneff is a fellow in the College of American Pathologists and the American Society of Clinical Pathologists and is certified by the American Board of Anatomical Pathology and Clinical Pathology. Dr. Anton has recently completed his residency in pathology at Georgetown University Hospital, Washington, D.C.

John Caffey, M.D., Pittsburgh, has been selected to receive the American College of Radiology's Gold Medal at the organization's annual meeting next April. Dr. Caffey is visiting professor of radiology and pediatrics at the University of Pittsburgh Medical School.

Samuel Martin, M.D., Philadelphia, has been named executive director of the Leonard Davis Institute of Health Economics at the Wharton School of the University of Pennsylvania. Dr. Martin is professor of community medicine at the University of Pennsylvania School of Medicine.

DR. MARTIN



DR. GOLDSCHMIDT

John W. Goldschmidt, M.D., Haverford, has been installed as president of the American Congress of Rehabilitation Medicine. Dr. Goldschmidt is dean of the College of Allied Health Sciences at Thomas Jefferson University and associate professor of rehabilitation medicine at Jefferson Medical College. He is a former recipient of the Lindback Foundation Award for distinguished teaching.

M. B. Hermel, M.D., Philadelphia, has recently delivered two papers on breast cancer, mammography, thermography, and xerography. One was presented at the International Biennial Congress of the International College of Surgeons in Lima, Peru; the other was presented at the annual meeting of the Eastern Pennsylvania Chapter of the American College of Surgeons.

Continuing medical education... now a PMS membership requirement

? ? ?

Must all PMS members meet the continuing medical education requirement?

YES! Bylaws (Chapter 1) provide that all Active, Senior Active and *Associate members must meet the c.m.e. requirement for membership.

Does this apply to physicians who are in administrative positions?

YES! There are many different ways of "keeping up." Each member should report what he is doing.

Are there any exceptions at all?

YES! There is a waiver provision in the Bylaws, and the Commission on Accreditation has a waiver application form.

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If you wish to apply for a waiver of the requirement, ask for an application form. Contact: Council on Education and Science
Pennsylvania Medical Society
20 Erford Road
Lemoyne, Pa. 17043.
Telephone: (717) 238-1635

editorials

American Indian health care—goal for all?

With National Health Insurance a virtual certainty within the next few years, controversy has increased. Proponents and opponents have become more vocal in their demands and volumes have been written or spoken on the various proposals now facing Congress. A favorite ploy of both sides has been to compare the English and Swedish medical systems with that of the present medical program in the United States to point out either the defects or strengths of public medical service as opposed to private medical service. In doing so, we have intentionally ignored an example that comes much closer to home, that of the Indian Health Service. Perhaps because the American Indian no longer poses a threat to the United States or because he really has little political voice, the problems of the American native are, for all practical purposes, disregarded.

The federal government, under the auspices of the Department of Health, Education, and Welfare, is totally responsible for the Indian Health Service. It has certainly established an unenviable record in the performance of these duties. Although the birth rate is two times greater than for the United States as a whole, the death rate in children from ages one to fourteen is three times greater.* The high death rate is primarily due to accidents and infectious diseases such as tuberculosis, dysentery, meningitis and pneumonia. Diseases of this sort are of extremely low incidence in the United States in general and are preventable. In short, Indian children have far too many health problems that have already been controlled in our country.

The physicians who are employed by the Public Health Service cannot be held entirely responsible for the failure of Indian health. Barriers exist in the form of widespread communities and language. But most of all, there is a financial barrier. One cannot place a physician in this type of situation with inadequate supplies and financial backing and expect him to "heal the people." Infectious disease control requires sanitation of water, sewage disposal, better living conditions, and health education. Obviously, this is not being accomplished.

Given the government's inept handling of Indian health which is but a small sector of the total medical service rendered in the United States, it boggles the mind to consider what will come of health care when millions of disadvantaged poor in the cities are added to the ranks of public medical service. Although these people are not as scattered geographically as the Indian, many of the same problems can be forseen. Sanitation, living conditions, and a potential language barrier head the list.

Under socialized medicine, the government owns and operates the medical care facilities, employs physicians and other health personnel within the system, and entirely finances the medical care costs of the patient. National Health Insurance is a system whereby the government will finance the medical care costs of the patient and while imposing some restrictions on physicians, will not technically be employing them. It is, indeed, a very short step from the latter to the former.

Do Americans really want to go the way of the Indian? The general state of health of the rest of our population proves that our current medical care system is better by far than the federally administered Brand X type. The government has proved itself to be less than acceptable as a health care provider.

David A. Smith, M.D.
Medical Editor

*Wallace, HM: The health of American Indian children. American Journal of Diseases of Children 125: 449-54, March 1973.

GESUNDHEIT!

correspondence

Abortion controversy continues

To the editor:

In response to the letter of Richard K. Kleppinger, M.D., published in the October 1974 issue of PENNSYLVANIA MEDICINE, concerning the Pennsylvania Medical Society's abortion position, several comments should be made.

First, Dr. Kleppinger implies that the stated policy of the Pennsylvania Medical Society regarding abortion reflects merely a position "adopted by the Board of Trustees and Counselors, May 1974." In fact, the abortion position referred to was established by the House of Delegates of the Pennsylvania Medical Society at the Annual Meeting in October 1970. Basically, this represented a reaffirmation of a policy established in 1967. In October 1972 by rejecting a proposed revision, and again in October 1973 by specific resolution, the House of Delegates by official action at the Annual Meetings reaffirmed the same position.

Second, rather than a gross misrepresentation of the Society's opinion, as Dr. Kleppinger holds, the position as published in the August issue of PENNSYLVANIA MEDICINE is clearly an accurate presentation of the Society's abortion position.

Third, Dr. Kleppinger seems to be of the mistaken opinion that it is mandatory for the Pennsylvania Medical Society, in formulating its ethical principles of medical practice, to concur with and condone all that is legally permissible. If such is the case, major portions of the Code of Principles of Medical Ethics will have to be changed. For example, it is not illegal to advertise one's practice or solicit patients. Does Dr. Kleppinger advocate that this ethical norm be abandoned by the Pennsylvania Medical Society? Similarly, there is no legal prohibition of fee splitting. Does Dr. Kleppinger advocate that the Pennsylvania Medical Society recognize the legality and condone the use of such a practice simply because it is legal?

The distressing aspect concerning the Pennsylvania Medical Society's position on abortion is the fact that, while continually reiterating its official position, the Society has done nothing about the obvious and flagrant violations of that policy that have recurred repeatedly in recent years.

Paul M. Hemler, M.D.
Camp Hill

Society's field team at your service

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practice management

Know the expert response to income tax questions

LEIF C. BECK, LL.B.
VASILIOS J. KALOGREDIS, J.D.
Bala Cynwyd

Two income tax deductibility matters seem to arise particularly often among physicians and we must say that these are areas of constant misinformation among doctors. They involve travelling for professional meetings and maintaining office space in homes. We hope our discussion of the present tax situations in each area will help clear the air, particularly at this season when winter vacations and tax returns will occupy more than usual attention.

Travel expense deductions

1. Foreign travel—There are admittedly a variety of foreign travel "gimmicks" offering physicians virtual tax-deductible vacations with only the slightest semblance of professional education. They are particularly identifiable by mailings with brightly colored travel brochures and almost no specific schedules for seminars. On the other hand, many foreign travel and meeting programs are quite legitimate. The problem is thus one of a physician's identifying how legitimate a tax deductibility claim for any trip really is before he begins packing his bags.

A recent revenue ruling (Rev. Rul. 74-292) denied a physician any deduction for expenses incurred during a 14-day trip to two foreign countries even though the program was sponsored by his local medical association. The trip was designed to combine travel to several cities in the two countries with a series of two-hour professional seminars in each country. The *entire expense* of the travel was ruled non-deductible on the basis that attendance at the seminars did not convert what was essentially a vacation into a business trip. Although any expenses directly related to the seminars (seminar fees, lunches between sessions, etc.) would nevertheless have been deductible as legitimate business expenses, the big items (travel, room and board) were denied as tax deductions.

Generally, a physician's travel expenses are deductible if the *primary purpose* is to further his practice or improve his professional skills. The most important factor in determining what is the "primary purpose" is the amount of time devoted to professional rather than personal matters. However, it is not the only factor and should not be mechanically applied. Where, for example, a surgeon travels to observe a certain procedure he might spend several additional days visiting friends and still claim the trip as a business activity.

Ordinarily, attendance at meetings and seminars qualifies as a professional activity. However, the IRS recently issued a news release stating that it would closely scrutinize certain conventions, trips and cruises during which only a small fraction of the time is devoted to business. The expenses will be disallowed if it appears that the primary purpose of the trip was pleasure—a vacation, for instance.

When travelling outside of the United States, only that portion of the total expenses related to business will usually be deductible. But even this apparently straight forward rule is limited to situations where the *primary purpose* of the trip is a professional one. If the *primary purpose* is personal, none of the direct costs of travelling are deductible; but if the *primary purpose* is business then a portion (but not all) of the expenses may be deducted.

'. . .the IRS recently issued a news release stating that it would closely scrutinize certain conventions, trips and cruises during which only a small fraction of the time is devoted to business. . . .'

Assume, for example, that Dr. B. travels to France primarily to attend medical seminars, but devotes only nine days of his two weeks away from home to professional activities. He would only be allowed deductions for 9/14 of the travel and related expenses. For the days in which seminars are held, his expenses (room, board, etc.) would be deductible.

There is also some special statutory help. Under Internal Revenue Code Section 274 (c) (2), the above prorations need not be applied at all to "primarily business" foreign travel if the entire trip is a short one (less than one week) or if less than 25 percent of the time away from home (presumably measured in days) is spent on personal matters. This can be especially helpful if seminars occur almost every day. Furthermore, in determining the number of days counted as

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd, Pennsylvania.

'. . .Congress itself is expressing concern over foreign travel programs. There is proposed legislation which would completely deny deductions for travel to foreign countries for meetings sponsored by U.S., state or local professional associations. . . .'

business days, the days spent en route to and from the destinations may be included, which makes meeting this test somewhat easier.

Finally, Congress itself is expressing concern over foreign travel programs. There is proposed legislation which would completely deny deductions for travel to foreign countries for meetings sponsored by U.S., state or local professional associations. It has not yet been enacted into law, and we doubt that it will become effective even in 1975, if at all. Nevertheless, doctors might recognize that the opportunities for tax deductible foreign seminar programs may well disappear in the future.

2. Domestic travel—All the rules discussed above deal with foreign travel, which has received so much IRS attention. When travelling domestically, *all* expenses (not just a prorated portion) en route are deductible so long as the trip is *primarily* for a business or professional purpose. Despite this apparent tax opportunity, however, we want to express words of caution.

We have seen doctors ruin otherwise fine, relaxing non-business vacations in their attempts to develop tax breaks. Such tax emphasis is one pitfall that should be avoided.

The following situation was presented to us recently and will hopefully illustrate the reason for care. Dr. Y. was planning to travel to Disneyworld with his wife and young daughter for the week of February 10-16. He received an advertisement announcing a medical meeting to be held on February 8-12. His immediate reaction was to combine the two events and thus turn the trip into a tax deductible "vacation." However, we jointly decided against it when it was recognized that he would be spending more than would be saved in taxes.

In his effort to develop the tax deduction he would have had to incur the expense of an additional two or three days at the meetings (lodging, food, etc. for himself and his family) as well as convention registration fees and incidental expenses. He also would have lost several additional days from his practice. Although the convention-related expenses would be tax deductible, their additional burden would have been greater than the tax benefits involved. For example, assume that Dr. Y.'s round trip plane fare to Florida was $300, the additional costs of attending the convention for three days was $400, of which $300 were business-related and therefore tax deductible, and that Dr. Y. is in the 50 percent tax bracket. In his search for a $150 tax saving (50 percent of *his* plane fare to Disneyworld), he would have spent $400 more at an after-tax cost of $250. This is hardly a bargain.

The lesson to be learned is to not jump at every apparent tax-saving opportunity without carefully considering the real cash cost of such a step. And besides the bad economics, his tax efforts might have taken the personal bloom off what should have been a true vacation away from the worlds of medicine and economics for the doctor and his family. The moral of this story is an old one: "Don't let the tax tail wag the dog."

3. Spouse's expenses—Another frequent question is whether expenses of wives are deductible when they accompany their husbands (or vice versa) on business trips. The two critical questions in determining this issue are: (a) Was the dominant purpose of her trip to further the physician-husband's profession in making the trip; and (b) Did the wife actually spend a substantial amount of time at the meeting assisting her husband to fulfill that purpose?

When the wife's business role is only nominal, the deduction for her portion of expenses has been consistently disallowed. Substantiating that her attendance is really useful to her husband's practice is very important but also very difficult. One must thus ask in many cases if the effort is even worthwhile—registering the wife, having her attend meetings she might not wish to attend, having her log in her activities, etc. She might decide it preferable to stay home!

4. Conclusion—This article only deals with a few of the important factors in determining whether an item of travel expense is deductible. A physician would be well advised to consult his tax advisors before incurring substantial expenses which have a business connection in order to determine their tax impact. This is far better than presenting the situation after the fact, perhaps when his tax return is being prepared—or worse yet, when it is being audited by the IRS. And, as suggested, he should keep his primary attention on the merits and personal considerations of the trip, rather than on the tax aspects. He should, once again, avoid letting the tax tail wag the dog.

Home office expense

Most doctors have routinely been advised by tax experts that they are allowed a "home office expense" income tax deduction for that portion of their homes used

for professional purposes. There had been some concern that the IRS would begin disallowing these deductions, but several Tax Court decisions within the last year or so have strengthened the allowability of the deduction.

A celebrated 1973 Tax Court case involving a Mr. Bodzin allowed a home-office deduction where the expense was "appropriate and helpful" to an attorney-employee of the Internal Revenue Service itself. This case represents an important precedent since it was the first case heard by the full Tax Court which allowed such a deduction. It certainly opened the door for physicians to feel far more confident in claiming a portion of their home expenses as business deductions where appropriate. There remain, however, real questions to be answered in each doctor's case.

1. Substantiation—In order to be allowed a home office expense deduction, the physician generally must clearly establish several things: (a) the business use of a portion of his home is "appropriate and helpful" to the conduct of his business, whether as proprietor, partner or corporation employee; (b) he regularly uses part of his personal residence for this purpose; (c) the portion of his personal residence so used; (d) the extent of such use; and (e) the actual amount of depreciation and expenses incurred in maintaining his residence for such use.

A 1974 Tax Court decision appears at first glance to have lessened the importance of keeping careful records. In this *Anderson* case the taxpayer introduced no evidence of costs (such as insurance, taxes, utilities, etc.) incurred in the operation of his home office, but the Court graciously approximated them and allowed deductions in that amount.

Despite the *Anderson* case, we urge that records (such as cancelled checks and receipts) be maintained to properly determine and prove the amount of the deduction being claimed. In case of an IRS audit, no agent is likely to allow much of a deduction (if any at all) without substantiation. Going to Court to seek the same good treatment Mr. Anderson received would hardly be a good alternative in view of the time, bother and cost involved with no assurance of a particularly successful result.

2. Computation—A physician's deductible expenses would usually include a portion of the rent paid if he is a tenant. If he owns his own home, as is generally the case, he could depreciate a portion of the total cost of his home. In addition, we generally advise our clients to claim the same percentage of such home expenses as heat, electricity and other utility bills, homeowners' insurance premiums, general maintenance to the house and grounds, domestics' wages for cleaning the home and the like. We usually do not include the home telephone bills among these items, but we rather separately claim a larger percentage as necessary for hospital or patient contact. Our experiences with the IRS on audits of these claims has been uniformly good so long as the amounts and percentages claimed could be substantiated.

YOU'RE RIGHT FRED, I *CAN* HEAR THE OCEAN!

Repairs and painting often present difficult home office deduction questions. Costs of repairs and painting to rooms other than the one used for business purposes are not deductible. However, the pro rata share of such items as exterior painting or roof repair would, for example, be deductible. Costs of painting and repairing a room used solely as an office or study would be fully deductible.

In allocating expenses, one of two methods is generally used. One is to compare the number of rooms devoted to a business purpose against the total number of rooms in the house. The other is to compare the square feet of space devoted to a business purpose against the total number of square feet. Although the above two are the most common, any other method that would be reasonable under the circumstances is acceptable, and it should certainly be worth a doctor's while to analyze his situation and decide what approach might put him in the best tax posture.

3. Conclusion—In light of the recent tax cases in this area, barring a change in the tax statute itself (which may be forthcoming in the next year or two), physicians will still be allowed to deduct their reasonable home office expenses. We hope we have showed how the deduction depends much on what records the physician himself has maintained. Then, with the guidance of his tax advisor, he should be entitled to his fair tax deduction.

Rules for office aides—tools to build good practice

PEG C. FLYNN, C.M.A.-A.C.
Washington

Serving as an assistant in a physician's office is not just another job—it is a career, important among the allied health professions. The Pennsylvania Society of the American Association of Medical Assistants is the official organization for members of this profession in the Commonwealth. The Council on Professional Relations and Services provides liaison services with the State Society for this organization which has received official commendation for its efforts in many areas and particularly for its achievements in fulfilling one of its objectives—"to provide educational service to increase the knowledge and professionalism of its members." In this article, Mrs. Flynn, chairman of the Education-Certification Committee for the Pennsylvania Society, AAMA, offers physicians a checklist for their aides.

For better office management and patient relations, here is a list of suggestions you may want your assistant to follow.

The Medical Assistant Should Always:

• BE FRIENDLY and considerate no matter how trying a patient may be. Her attitude can greatly influence the patient's opinion of you before you actually treat him. She is your agent and must maintain the dignity of your profession.

• BE NEATLY GROOMED in good taste; her appearance is important in the patient's forming a first impression of you. If she wears a uniform, it should be spotlessly clean and her shoes must be kept polished. If she does not wear a uniform, be sure that she dresses properly for a medical office.

• KEEP the reception room looking neat and cheerful. A drab waiting room will only make an ill patient feel worse. The medical assistant should check your waiting room at intervals during the day to see that it keeps its neat appearance. She should also be sure that the chairs and tables there are kept in good repair. Being alert for potential hazards can prevent accidents.

• KEEP her desk tidy and uncluttered, particularly if it is in the reception room. Again, it gives a better impression of the office as a whole.

• SMILE when answering the phone. Her ability to handle the phone can make a new practice flourish or hinder a busy one. The patient cannot see how many things she is trying to do at the same time and will not understand if she is grouchy or unfriendly.

• RECORD appointments with the utmost care; they should be written in ink. The flow of patients must be smooth, as your time is valuable. If your assistant must remove a name, she should draw a line through it and enter the vacated time at another spot in the day book. This provides a permanent record of a cancellation or a patient's failure to keep the appointment. Should a patient cancel and not reschedule, your assistant should record the information on the patient's chart as well as in the appointment book. There are known cases of a physician's losing a suit for abandonment because the cancellation was not properly recorded.

• PRACTICE good bookkeeping habits. The accounts receivable must be kept accurately to assure good relations with patients. Errors can cause embarrassment to everyone concerned. Your medical assistant may sometimes have to act as a bill collector. She must do it in a manner that will not irritate the patient but will bring about payment. The Federal Trade Commission has laws which regulate debt collection. If you are not aware of them, obtain a copy of the guidelines from your local FTC Bureau, Department of Industry Guidance.

• KEEP medical records accurately and current. Good records provide legal protection in addition to aiding optimal patient treatment. A good rule for your medical assistant to follow is: DO IT NOW. Procrastination is a great danger and the longer a task is put off, the harder it becomes. If she completes the records daily, there is no danger of your mistreating a patient because of the lack of complete records.

• BE SURE to file all records accurately. It is best if your medical assistant maintains a system by which she can locate within seconds the information or records you need.

• TYPE NEATLY. It is a reflection on you as well as your assistant.

• REMEMBER to smile. It increases her face value.

The Medical Assistant Should Never:

• KEEP any records or appointment books where the patients may see them. Many offices keep a book which patients must sign or have a list of appointments where it can be seen by them. These methods should be avoided because they allow the patients to see the names of others being treated. This is a breach of medical ethics and an invasion of privacy.

• BE OVERPROTECTIVE of you. She should screen your calls as you direct but she should not block them all. The patient has a right to speak with you but is almost always willing to do it at your convenience.

• ANSWER the phone without a pen or pencil in hand to record a message. She may be sidetracked before she has a chance to follow through with the message and the written one will jog her memory.

• GIVE information about a patient by telephone. There is no way to be sure who is requesting the information, and giving it in this manner betrays the doctor-patient relationship. Third party requests for information by phone are on the increase since it is cheaper to call than to write. For this reason your assistant must be very cautious about what information she gives. Sometimes the call may be just for clarification of something she has submitted in writing. If the caller can prove his identity to your assistant's satisfaction, she may clarify the question. This is particularly applicable in calls from third parties—insurance companies and Blue Shield.

• TAKE it upon herself to offer any medical advice. Every office should have a set policy in this regard.

• TAKE shortcuts in bookkeeping; they only lead to problems later.

• HESITATE to ask what may seem to be "dumb" questions. They are easier and cheaper to handle than dumb mistakes.

Continuing education... now a PMS membership requirement

for more information, contact:
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Pennsylvania Medical Society
20 Erford Road
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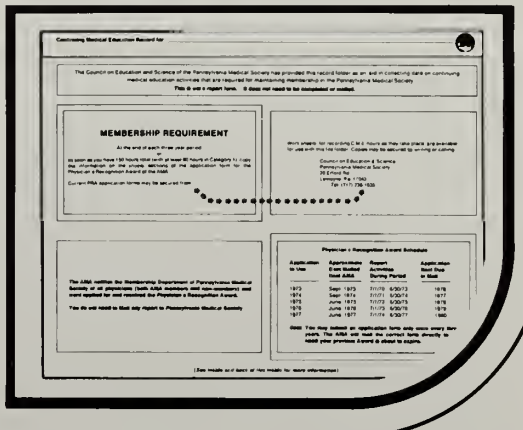

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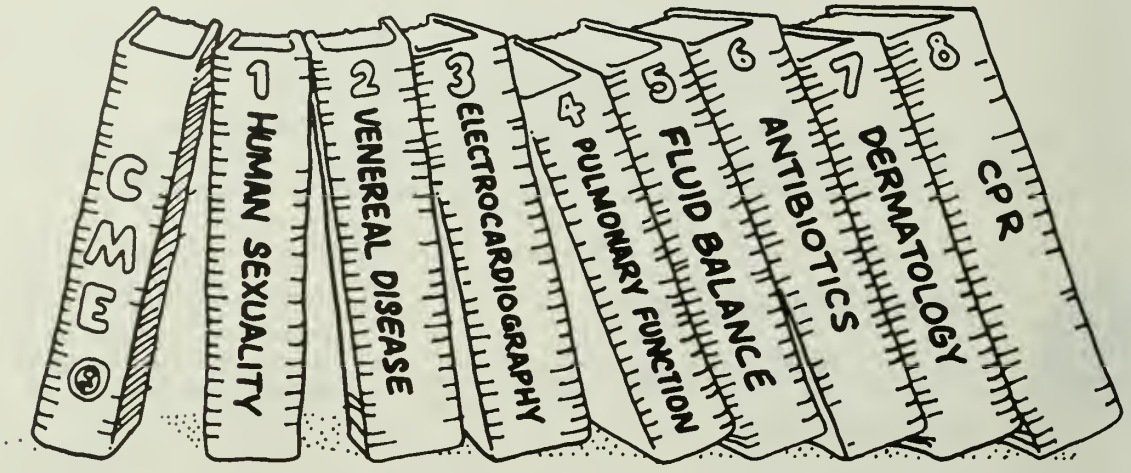

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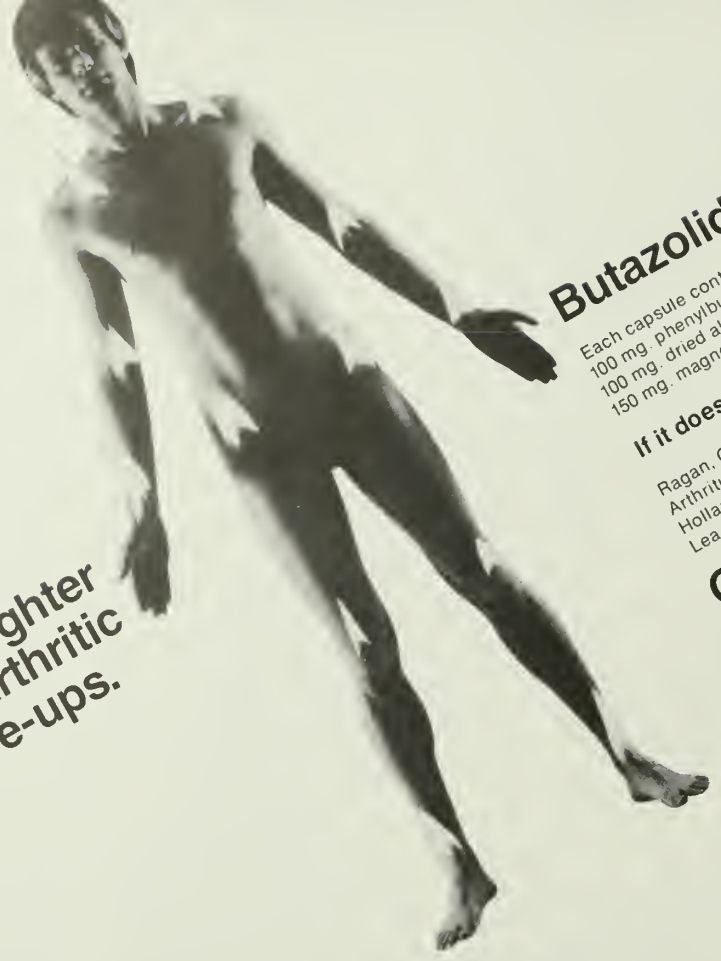

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Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients, history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia, history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension, thyroid disease; systemic edema, stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions, complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug, its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia, ulcerative stomatitis, salivary gland enlargement.

(B)98-146-070-J (10/71)

For complete details, including dosage, please see full prescribing information.

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AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic endproducts do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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The Chinese acute abdomen

RUSSELL B. ROTH, M.D.
Erie

Dr. Roth was one of twelve American Medical Association physician delegates who visited the Peoples Republic of China as guests of the Chinese Medical Association in July 1974. He is the immediate past president of the AMA, former speaker of the AMA House of Delegates, and a former chairman of the Pennsylvania Medical Society's Board of Trustees and Councilors, having served on that body for ten years. He is currently a member of the PMS Judicial Council and continues his practice of urology in Erie.

WHEN Wong Jin Lo was seized with severe abdominal pain while working in the field, it didn't take long to secure help. The "worker doctor" on his production team was in the same field for the harvesting of the sorghum, and it was quick work to get old Wong to the roadside where one of the commune tractor trucks stopped to pick him up to take him to the brigade health station. There the barefoot doctor looked him over, judged his pain to be real, his abdomen a bit board-like, and his temperature subnormal. Taken in conjunction with the fact that Wong had been known for over a year to have symptoms of an ulcer and had presumably been on treatment for it, the barefoot doctor decided this was beyond her competence. Transportation was quickly arranged to carry Wong to the General Hospital for the Nan Kai District. This was not entirely a random choice. One other hospital would have been a little closer, but the barefoot doctor knew that at Nan Kai General Hospital they were especially interested in the "acute abdomen" from a research point of view.

Actually, the hospital is a teaching hospital associated with the Tientsin Medical School, but it is also a center for Chinese Traditional Medicine. Its principal research project is the nonsurgical management of what is, in most other places, considered to be the "acute surgical abdomen." In 73.7 percent of such cases, no surgery is performed.

Wong had blood drawn for laboratory studies, and an upright film of his abdomen was taken. It showed free air under the dia-

phragm. It was felt that the diagnosis of a perforated ulcer was confirmed. Treatment was started with the insertion of two acupuncture needles—one in the right leg anteriorly just lateral to the tibia and one in the midline of the abdomen between the umbilicus and the xiphoid process. These were attached to pulsating electrical current. A nasogastric suction tube was passed, I.V. fluids (dextrose 5 percent in N. Saline) were started; and since the abdominal pain was slow in subsiding, he was given 50 mgm of demerol in the I.V. tubing. Within twenty-four hours the abdominal pain had subsided. Intermittent needlings were continued during the next forty-eight hours, but after the second day the nasogastric tube was removed and he was given small amounts of a dark brown herbal decoction by mouth. This was then followed by small bland feedings. Daily acupuncture treatments were continued, and the diet was rapidly advanced. Herb medicine was also continued four times a day. Wong, when we saw him on the fifth day was doing well.

It is difficult to come to grips with herb medicine. Actually it is quite often compounded of animal substances and minerals in addition to herbs. For instance, if the medicine is to be given for kidney stones, the physician may start out with one of his three favorite herbs for renal colic, to which will be added other ingredients as may be indicated by traditional theory according to age and sex, pulse rate, temperature, blood pressure, presence or absence of nausea and vomiting, and kindred factors. As a result it becomes unlikely that two patients will receive precisely the same medications. This makes it difficult to assess therapeutic efficacy.

On the other hand, it is quite possible to compare a substantial series of patients treated by nonsurgical methods with an equivalent series treated by standard operative management. It is manifestly not appropriate to compare the 75 percent of "conservatively" managed patients with the 25 percent who undergo surgery because the 25 percent includes the most seriously ill patients on admission plus those who do poorly under nonsurgical treatment. Roughly 20 percent are operated upon at once.

Once again judgments which need to be made on the basis of valid statistical comparisons seem to be difficult because of the paucity of figures, but at this particular hospital the overall mortality rate for acute appendicitis is given as 0.2 percent. This would indicate relatively little difference between a series in which only 10 percent of the cases were operated upon and the results where all cases are subjected to appendectomy. One is left with a number of unanswered questions, however, when it is elicited that in a series of 319 cases of ruptured appendicitis the death rate was under 3 percent for group, but was 30 percent in the patients for whom operation was deemed to be essential. Standard nonoperative treatment of acute appendicitis was illustrated by the case of a 62-year-old woman who was admitted to the hospital with a history of two days of abdominal pain, nausea, vomiting, and a fever of 102°. White blood count was 13,100 with 84 percent polymorphonuclear neutrophil leukocytes. She was immediately started on acupuncture and was given tetracycline intramuscularly for twenty-four hours. This was then continued orally for a second day, and traditional herb medicine was begun. The temperature dropped to a sustained normal level on the second day. Regular meals were resumed on the fourth day, and it was proposed that she be kept in the hospital for ten days.

Curiously, however, the acupuncture clinics seem to abound with patients labeled as suffering from "chronic appendicitis." It would seem as though patients with intermittent episodes of abdominal discomfort are so diagnosed and are likely to be managed as outpatients—usually by acupuncture treatments at weekly intervals for perhaps twenty or more weeks. Moxibustion treatments are also used with the burning punk-like sticks of dried artemisia plant burning in a box applied to the abdomen or as balls of moxa pushed on to the end of acupuncture needles or held in little cone-like baskets at the end of needles.

The impression should not be left that most cases of appendicitis or perforated ulcers in China are treated as has been described here. This is an admitted experimental research approach. In the United States we have known experimental projects for the nonsurgical treatment of acute abdominal conditions, but most such projects have been abandoned.

Generally, in China, acute appendicitis is treated by appendectomy, and a perforated viscus is also operated upon promptly. Usually these abdominal operations are done under traditional Western-type anesthesia, since acupuncture has admitted disadvantages. It is said to work better when there is an opportunity to "condition" the patient to the procedure, educate him to the technique, and try it upon him for effectiveness. In addition, acupuncture "analgesia" does not give muscle relaxation such as the surgeon might like to have, and it does not eliminate the pain which is attendant upon traction on the viscera. Some cases are done under acupuncture, but generally this is to prove it is possible, or as a demonstration.

The "Western" surgeon is likely to be impressed once he has seen these cases, and is usually highly skeptical until that time. Once he believes what he sees and accepts his Chinese colleagues as honest and sincere people, it may give pause for reflection. People do survive ruptured appendices and perforated ulcers without surgery. Skillful medical management may increase the survival rate. No one can as yet evaluate the follow-up, the delayed complications, the adhesions, or the intestinal obstructions which may ensue. There is little, to date, to lend any credence to the idea that nonsurgical management is better than surgery. It may be worth exploring under controlled conditions, but my own reaction is to devoutly hope to be included among the surgical controls. □

Hemophilia in childhood

FRANCES McNIELL GILL, M. D.
ELIAS SCHWARTZ, M.D.
Philadelphia

This is the fourth article in the hemophilia series. It was prepared by Children's Hospital of Philadelphia and the department of pediatrics at the University of Pennsylvania School of Medicine. Research was supported in part by contracts from the National Institutes of Health and the Commonwealth of Pennsylvania.

THE severe hemophilic disorders are usually diagnosed in early childhood. A history of bleeding in the family may suggest the diagnosis of a hereditary bleeding disorder. Factor VIII deficiency (Hemophilia A) and Factor IX deficiency (Hemophilia B) are inherited as sex-linked recessive disorders, while von Willebrand's disease has an autosomal dominant pattern of inheritance. In Factor VIII and IX deficiencies, children with less than 1 percent of the specific factor have severe manifestations, usually with frequent spontaneous bleeding episodes. Those with factor levels from about 2-5 percent rarely have spontaneous bleeds. In patients with factor levels greater than 5 percent bleeding episodes result from trauma, including dental extractions and surgical procedures. The degree of severity is consistent within the affected family.

General Problems

The diagnosis of hemophilia in a child is a great shock to the parents, even if there is a positive family history. The prospect of raising a child with this disease may be overwhelming. The adequacy and sensitivity of the counseling of the family may have a profound effect on the relation of parents and child and on the child's subsequent ability to live a relatively normal and useful life. As the child grows, these discussions should also include him so that he will eventually assume some responsibility for his activities and for the care of bleeding episodes. Educational literature may be of help. *How to Live with Hemophilia* by James Vogel (published by Interbook Incorporated, 545 Eighth Avenue, New York, N. Y. 10018) is a good general introductory book for parents. *Diagnosis and Treatment of Hemophilia, a Practical Guide* by Herbert Strauss (Department of Pediatrics, Albany Medical College, Albany, New York, 12208., 1972) is a very useful guide for physicians and sophisticated parents. The National Hemophilia Foundation and its local chapters have educational materials and other supporting services for families with hemophilia.

Although the toddler and young child have an increased incidence of bleeding episodes, the child must be allowed to explore his world and to develop normally. Simple aids such as the use of padding to protect the young child's knees, may decrease the injuries. Such padding can be improvised in many ways, for instance with the use of foam rubber in trouser knee pockets, pot holders sewn to the knee areas, or the use of foam rubber held in the knee areas by tennis wrist bands.

The general guidelines we follow for therapy are given in Table 1. Either lyophilized concentrate of VIII or cryoprecipitate is used for the minor bleeding episodes in children with Factor VIII deficiency. Fresh frozen plasma may also be used. In major bleeding episodes, attainment of high factor levels with small volumes is made possible by use of the lyophilized product. In the pa-

TABLE I
Factor Dosages for Bleeding Episodes in Hemophilia

Factor VIII Deficiency

	Minor Episodes*	Major Episodes+
Fresh-frozen plasma		
Initial dose	15 ml/kgm	——
Maintenance	11 ml/kgm every 12 hours	——
Cryoprecipitate°		
Initial dose	1 shelf unit/6 kgm	1 shelf unit/3 kgm
Maintenance	1 shelf unit/8 kgm every 12 hours	1 shelf unit/6 kgm every 12 hours
Commercial lyophilized factor VIII		
Initial dose	12 I.U./kgm	28 I.U./kgm
Maintenance	8 I.U./kgm every 12 hours	14 I.U./kgm every 12 hours

Factor IX Deficiency

	Minor Episodes*	Major Episodes+
Fresh-frozen plasma		
Initial dose	15 ml/kgm	——
Maintenance	11 ml/kgm every 24 hours	——
Commercial lyophilized concentrate containing factor IX		
Initial dose	15 I.U./kgm	40 I.U./kgm
Maintenance	11 I.U./kgm every 24 hours	15 I.U./kgm every 12 hours

* Minor episodes include hemarthroses, soft tissue bleeds, and superficial lacerations.

\+ Major episodes include CNS hemorrhages, bleeds threatening the airway, retroperitoneal bleeds, and surgical coverage. Since the distribution space for factor IX is greater than for factor VIII, larger dosages of factor IX are required.

° A shelf unit of cryoprecipitate in our institute contains 100 I.U. of factor VIII on the average.

tient with Factor IX deficiency, minor bleeds are treated with fresh frozen plasma. In life-threatening situations such as intracranial hemorrhages or for emergency surgery, lyophilized concentrates are used. Either fresh frozen plasma or cryoprecipitate may be used in the treatment of von Willebrand's disease. Immobilization of the affected joint or muscle and cold applications to the area during the actue phase are also valuable measures. Despite the difficulty of venipuncture in some young children, venous cut-downs may increase the child's problems and should be avoided if possible. In those children requiring prolonged treatment, especially with fresh frozen plasma, there is a possibility of fluid overload after several days of therapy because of accumulation of protein. The use of lyophilized products and diuretics may be essential if early signs of vascular overload appear.

The benefits of home therapy for the child with hemophilia are several: earlier treatment of bleeding episodes, thereby decreasing pain and interference with function; fewer trips to the hospital; less time lost from school; and less anxiety for the child since there are fewer interactions with medical personnel. However, home therapy may be impossible in some children either because of parental fears and attitudes or because of the difficulty of venipuncture in young children.

The amount of time the child misses from school can be decreased by encouraging the child to attend school whenever possible. For example, a child with a joint hemorrhage may attend school if the joint is properly immobilized and if, in the case of lower extremity bleeds, the child is proficient with crutches. If a prolonged absence from school is anticipated, a homebound tutor should be involved as soon as possible. Many of the child's difficulties arise because children at school recognize him as different. The child and his parents may require much support and extra counseling when school problems arise. Vocation counseling is important to help the older child become a fully functional adult.

Special Bleeding Problems

The passage of the infant through the birth canal subjects the entire infant and especially his head to high pressures. It is remarkable that more infants with hemophilia do not have intracranial bleeding.

Many infant boys who are later found to have hemophilia have been circumcised in the first few days of life without excessive bleeding, although others bleed profusely. However, before a circumcision is done on any infant, the physician should take a careful family history regarding bleeding problems on both maternal and paternal sides. If there is any history of unusual bleeding, the child should be tested for hemophilia and other bleeding disorders. Since factor VIII does not cross the placenta, a low level of factor VIII in a term baby raises the possibility of hemophilia. Since factor IX is frequently lower in the normal newborn infant than in the older child, there is occasionally difficulty in diagnosing mild hemophilia B. Children with severe hemophilia B have a very low level of factor IX at birth. If laboratory evidence of a hereditary bleeding disorder is found or if doubt remains, circumcision should not be done until definitive studies have been completed.

Mouth cuts and tears of the frenulum can be major problems in

the child with hemophilia. Recently, we have treated such injuries with topical thrombin and epsilon amino caproic acid (EACA), using factor replacement only when the simpler treatment is ineffective. Epsilon amino caproic acid is given in four daily oral doses of 100 mgm/kgm per dose (total daily dose of 400 mgm/kgm and not exceeding 24 gm per day) and is continued for five to seven days. Topical thrombin, preferably in powdered form, is applied on a cotton swab directly to the bleeding site and held with slight pressure for five minutes. A clot will usually form promptly. If it is dislodged and bleeding recurs, the parents may reapply thrombin to the site. A liquid diet is given to minimize the risk of dislodging the clot. Despite the success of EACA and topical thrombin in treating some mouth cuts and frenulum tears, others may require intensive treatment with intravenous clotting factors for seven to fourteen days until the cut heals.

Joint bleeds and severe muscle bleeds are frequent in childhood. These require early and adequate therapy to prevent permanent deformity. Recurrent bleeds in one joint or limitation of motion persisting past the acute bleeding episode require evaluation at a hemophilia center.

Dental problems may be major ones and are best prevented. The importance of early and regular dental visits, at least three per year, and the use of fluoride either in water or in topical treatments cannot be overemphasized. If prevention is not successful, dental repairs may be safely done with some precautions. Transfusion of clotting factors is usually not necessary for repair of dental caries without local anesthesia. Anesthesia, if necessary, should be local infiltration and not a mandibular block. If infiltrations are to be given, the child should be treated to raise his factor level to 30 percent prior to the procedure. Extractions of teeth are often possible on an outpatient basis if the child is prepared ahead of time with EACA and one treatment of factor and then observed carefully for any unusual bleeding. The use of acrylic splints to apply pressure directly to the socket is also helpful. For complicated procedures, hospitalization may be required.

With the availability of specific concentrates of factor VIII, elective surgery to correct congenital abnormalities has been performed in children with factor VIII deficiency. This should be done at a hemophilia center. It is more difficult to provide sufficient coverage for the patient with factor IX deficiency since large volumes of plasma may be required. Because the concentrate which includes factor IX has a major hazard of transmitting heptatitis and perhaps of causing thrombosis because of activation of clotting factors, we are not doing elective surgery in these children at the present time.

The appearance of an inhibitor to factor VIII or factor IX is a major setback in the treatment of a child with hemophilia. Since treatment of the common bleeding episodes becomes a major problem, the life of the child and his parents becomes more difficult. It is very hard for the children and the parents to accept the lack of the usual means of treatment and to agree to the increased restriction of activity which may be necessary.

When the child with hemophilia and his family have access to early and adequate treatment by pediatricians, hematologists, orthopedists, dentists, and psychiatrists with an interest in hemophilia, the prospect for a long and useful life is very good. □

Cobra bite in Philadelphia

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COBRA bites are not unusual in Africa and Asia where this common snake resides. Physicians in these areas are generally familiar with the clinical symptoms and treatment of such bites. However, when a victim of a cobra bite in a nonzoological setting presents himself to the accident ward of a large American city hospital, extreme discomfiture must reign. Such was the case reported below.

Case report

A 15-year-old black male presented himself at the accident ward of Albert Einstein Medical Center on Thanksgiving Day, Nov. 11, 1973, with the chief complaint of a painful left thumb. Twenty-five minutes prior to this, he claimed to have been bitten by a pet cobra at home during an attempt at milking venom.

He applied a tourniquet to the extremity and sought medical attention.

Initial treatment consisted of incisions over both fang marks on the dorsum of the thumb. An incredulous house staff was partially mollified when two police officers, on request, carefully removed the snake from the basement of the patient's house and brought the cobra to the accident ward in a metallic garbage can. On initial examination of the patient, vital signs revealed a blood pressure of 160/100, pulse rate 120, and respirations 22. The skin was moist and clammy. In addition to the fang marks, the thumb was edematous. The remainder of the examination was normal. The blood pressure returned to normal within twenty-four hours. Laboratory studies showed a leukocytosis which was transient. Hemoglobin, platelets, blood sugar, creatinine, blood urea nitrogen, fibrinogen, electrolytes, albumin, globulin, bilirubin, serum glutamic oxaloacetic transaminase, serum glutamic pyruvic transaminase, lactic dehydrogenase, creatine phosphokinase, prothrombin, partial thromboplastin time, lipase, urine analysis, chest x-ray, and electrocardiogram were all normal.

Three hours after admission, the obviously anxious patient complained of a sleepy feeling, became nauseated, and vomited. The accident ward by this time was overcrowded with reporters and public health officials. There was some delay in reaching personnel from the Philadelphia zoo because of the holiday. However, four hours after the bite, positive identification of the snake was made (Naja Naja) and specific antivenom was obtained. After a test dose and priming with steroids and diphenhydramine hydrochloride, 120 ml of State Razi Institute cobra antivenom were given intravenously without untoward effects. In addition, the patient was treated with human tetanus immune globulin and ampicillin. Cardiac, respiratory, and neurological monitoring were instituted for the first forty-eight hours. The involved thumb developed swelling with slight necrosis which gradually resolved. The patient remained otherwise well and was discharged one week after admission.

According to Reid,[1] the physician treating a snake bite must answer three questions. Was significant venom injected? Is systemic poisoning present? How severe are the systemic symptoms, particularly in terms of antivenom requirements?

In our case, the patient showed local swelling and experienced pain at the site of the bite followed by slight necrosis. In cobra bites swelling typically occurs several hours after the bite, and pain may persist for several days. However, local pain may be minimal or absent in severe poisoning. Similarly, the extent of necrosis and swelling, minimal in this patient, bears little correlation with the development of systemic poisoning.

The most common symptom of snake bites is fright, both in the patient and physician. The transient hypertension, sweating, tachycardia, and vomiting as exhibited by our patient can falsely suggest a more serious illness and initiate unnecessary therapy.

Systemic symptoms produced by the venom of the cobra are predominately neurotoxic, the earliest being drowsiness starting one to five hours after the bite. This is shortly followed by ptosis, facial and glossopharyngeal paresis, generalized paresis, and respiratory arrest. It has been clearly established by Reid[2,3] that antivenom is only indicated when general systemic poisoning is present and has no influence on local symptoms. In addition Reid notes that in bites of man by poisonous snakes, more than one-half of the victims will have minimal or no poisoning. Only one-quarter will develop systemic poisoning. Therefore, poisonous snakebite is not synonymous with snake bite poisoning. In retrospect, antivenom was not required in the treatment of this case.

However, even when indicated, antivenom therapy is not always effective and carries the danger of anaphylaxis and serum reactions.[4] Adequate antivenom therapy in systemic cobra bites involves the intravenous infusion of at least 100 ml of horse serum which may have to be repeated hourly. Banerjee[5] has proposed a pharmacological approach to the treatment of neurotoxicity from cobra bites. The neurotoxin from cobra venom has a neuromuscular blocking action similar to curare. Unlike curare, it is slower in onset and cannot be removed by washing out the endplate. The "neurotoxin" block can only be reversed or diminished with cholinesterase as long as it is partial. In a small therapeutic trial, neostigmine and atropine was found to produce one hundred percent survival with a rapid rate of recovery compared to a forty percent survival in conventionally treated cases with antivenom, steroids, and respiratory assistance. The neostigmine-atropine regime required early initiation and sustained therapy to maintain adequate blood levels.

In addition to the therapeutic questions raised by this case, the fact remains that a fifteen-year-old could purchase and be shipped by interstate carrier a potentially lethal animal. Apparently no federal, state, or local law had been abrogated by this act. Unfortunately, the press reports tended to make a local hero of the patient. Despite this, the victim lives, and the cobra resides in the Philadelphia zoo. □

This paper was prepared by the department of medicine, Albert Einstein Medical Center, Philadelphia. Dr. Tiger and Dr. Brecher are attending physicians at the center and are both certified by the American Board of Internal Medicine. Dr. Bevan is a resident at Einstein's Northern Division, and a diplomate of American Board of Internal Medicine.

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Practical application of fiberoptic colonoscopy in the management of colonic disorders

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INDIRECT inspection of the colon became possible in 1895 with the discovery of roentgenography by Wilhelm von Roentgen.[1] The sigmoidoscope, developed shortly thereafter by H. A. Kelly and the barium contrast enema study, introduced by F. Haenisch in 1911,[2] remained the only available nonsurgical means of inspecting the interior of the colon until the late 1960's.

Inspection of the colon beyond the limits of the rigid sigmoidoscope and the barium enema study became possible with fiberoptic technologic advances which permitted development of the flexible fiberoptic colonoscope. In 1969 the first colonoscope became available in this country, and instruments are presently available in two lengths; one measuring 105 cm, capable of reaching to the splenic flexure, and the other measuring 165 to 188 cm, with the capability of reaching the ileum. A lens system attached to coherent flexible glass fibers, a lighting system attached to incoherent glass fibers, a suction biopsy channel, and lens washing equipment are contained in a flexible

Figure 1 (a). Flexible fiberoptic colonoscope.

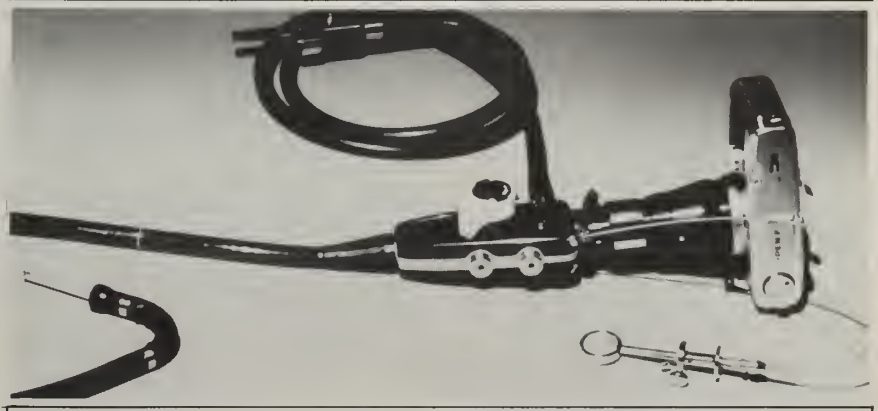

Figure 1 (b). Flexible fiberoptic colonoscope with photographic equipment attached.

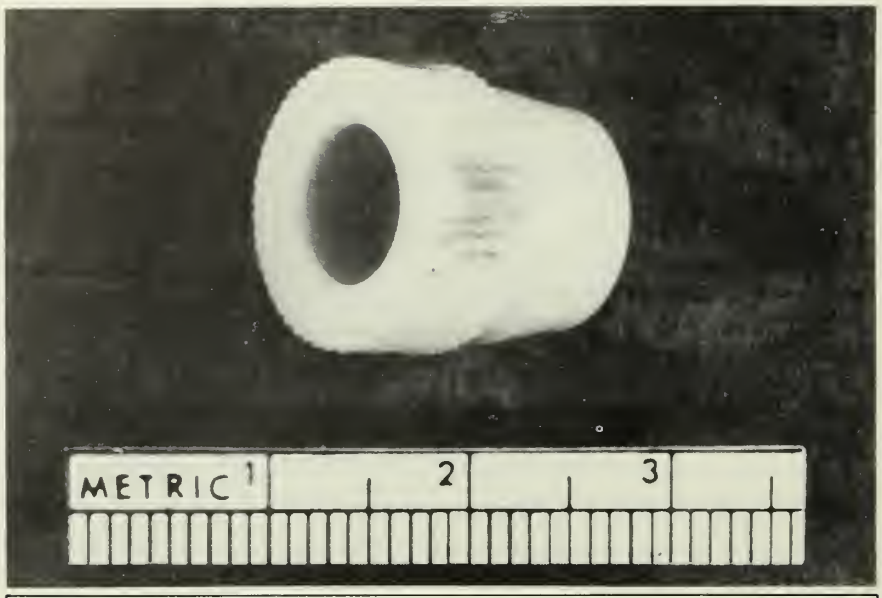

Figure 2 (a). Foreign body—plastic enema gasket.

shaft. The viewing lens, a handle to manipulate the working tip, controls for the introduction of air or aspiration, and channels for the introduction of forceps or snares are housed in the head of the instrument. Photographic equipment can be attached to the lens system for still and motion photography (Fig. 1).

The time-honored methods of examining the colon, sigmoidoscopy and barium enema examination, remain the first choice of investigation. Colonoscopy is too expensive to be used for screening purposes and should be reserved for those cases in which the two above procedures are unrevealing, but clinical signs and symptoms suggest disease.

Colonoscopy is performed in a hostile environment which may contain materials that make inspection difficult or even impossible. The colon, therefore, must be free of particulate matter and opaque fluid. Energetic preparation, with several days of saline cathartics and liquid diet, has proven effective. The examination can be conducted by the experienced endoscopist without radiographic guidance or surveillance. A small amount of sedation frequently permits the procedure to be accomplished with less discomfort than that accompanying sigmoidoscopy. Diagnostic colonoscopy is performed in a comfortable Sims position without anesthesia. Valium is given intravenously only when polypectomy is performed because general anesthesia is not only unnecessary but hazardous.

Figure 2 (b). Retrograde colonoscopic removal of foreign body.

Indications

Inflammatory Disease—Several facts have become evident as a result of the increased use of the colonoscope in diverticular disease. The activity of the diverticular process is inclined to be underestimated by barium enema examination. Strikingly acute changes have been noted colonoscopically in the absence of roentgenographic evidence. The number and size of the diverticula seem greater in all regards when viewed colonoscopically, perhaps because air is introduced into the lumen of the colon with pressure. The characteristic changes of mucosal edema, submucosal fibrosis, bowel wall rigidity, friability, bleeding, and mucopurulent exudate are easily recognized by the endoscopist. The combination of diverticular disease with pedunculated polyps is frequently suggestive of cancer, and the distinction between malignant and nonmalignant processes has been made with the colonoscope on many occasions. Differentiating cancer from diverticular disease becomes vitally important in the older, poor-risk patient for whom nothing short of cancer would serve as an excuse for laparotomy and colectomy.

Granulomatous disease of the colon and atypical ulcerative colitis have been diagnosed with the colonoscope following "normal" roentgenographic findings. The greatest demand for diagnostic assistance is in the exclusion of cancer in the chronic ulcerative colitis patient; and unfortunately, a negative colonoscopic examination does not rule out the possibility of cancer. The invasive type of cancer associated with this disease is prin-

cipally intramural and can escape detection by colonoscopic biopsy. Chronic ulcerative colitis complicated by stricture should continue to be viewed as malignant until proven otherwise by resection.

Assorted inflammatory lesions, such as ischemic colitis, pneumotoses cystoides intestinalis, and unspecified colitides have been colonoscopically diagnosed independent of roentgenography; and roentgenographic findings related to these diseases have been corroborated. When radiation proctitis and colitis, because of patient discomfort and rigidity of the bowel, prevent adequate examination with the sigmoidoscope beyond the 6 to 7 cm level, the flexible fiberoptic colonoscope is helpful.

Complications resulting from colonoscopy performed in the presence of acute inflammatory disease have been reported. The preparation and mechanics required for the proper performance of colonoscopy may cause progression of an acute bacterial process. Acute toxic megacolon has been described as a result of the examination performed in the presence of acute ulcerative colitis. With these considerations in mind, the hazards of colonoscopic examination must be weighed against the benefits.

Foreign Bodies—The need to remove foreign bodies from the colon arises infrequently. A plastic colostomy irrigation gasket lost through the stoma was successfully recovered, without laparotomy, from an individual with irradiation injury that prevented its passage into the rectum (Fig. 2).

Anastomosis—Information gained from inspection of surgical anastomoses has permitted safe colostomy closure when the barium enema examination has been indefinite. Interpreting a normal lumen when there is radiographic suspicion of anastomotic tumor recurrence is difficult because the anastomosis can appear normal while a large extramural tumor is present (Fig. 3).

Figure 3. Extramural tumor without mucosal involvement.

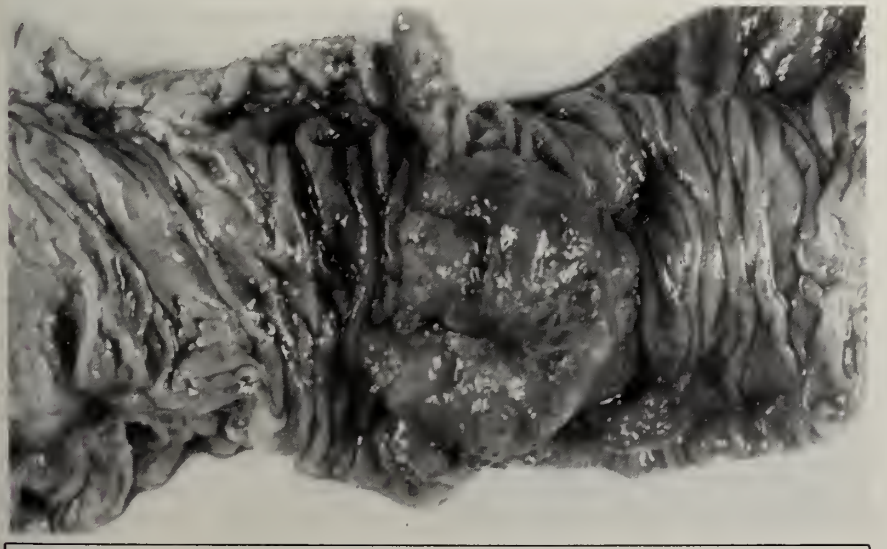

Figure 4. Polypoid carcinoma of the splenic flexure not revealed on three separate barium enema examinations.

Polypoid Disease

Colonoscopy has been of greatest benefit in the management of polypoid disease. The diagnostic capability which allows for the discovery and definition of polypoid lesions and the ability to remove polyps with an electrosurgical polyp snare or forceps account for the impact of the colonoscope on polypoid disease of the colon.

Polypoid lesions, both benign and malignant, have been diagnosed repeatedly in patients presenting with gross rectal bleeding and for whom roentgenographic studies have been unrevealing. A polypoid carcinoma has been discovered in the region of the splenic flexure after three barium enema examinations, done at separate institutions, failed to disclose the lesion (Fig. 4). In almost fifty percent of the cases where the barium enema examination has revealed a polyp or polyps, additional polyps have been found at colonoscopy.[3,4]

The absence or presence of a

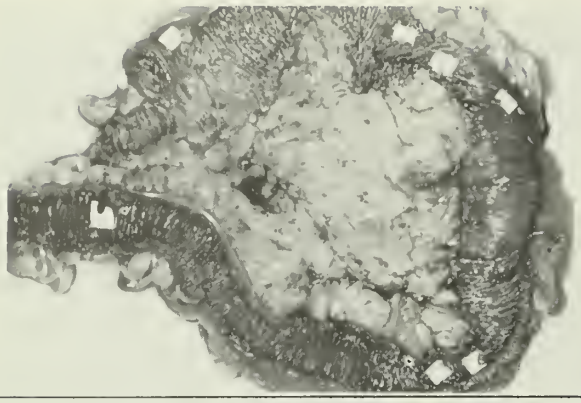

Figure 5. Operative specimen containing eight polyps, one of which contained an in situ carcinoma.

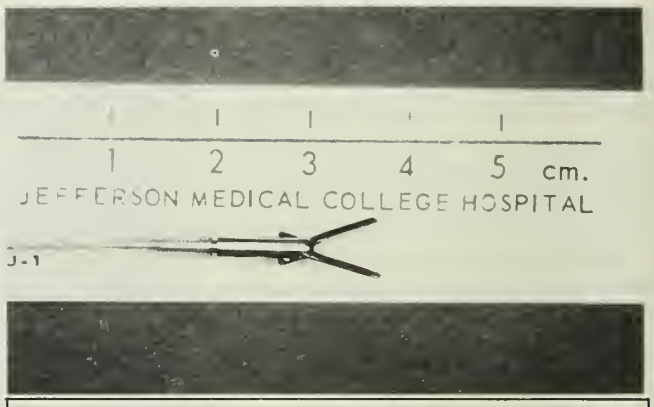

Figure 6. Electrosurgical scissor-type forcep developed by author.

pedicle or pseudopedicle frequently cannot be determined by barium enema study, and the colonoscope permits inspection as well as biopsy. The startling presence of a cancer has been observed following an almost certain diagnosis of a nonmalignant process by the radiologist. It is no longer advisable to place polypoid lesions under radiographic surveillance without colonoscopic corroboration, since we have all witnessed serious errors resulting from this practice.

When colonoscopic examination reveals three or more polyps at disparate sites in the colon, surgical plans made well in advance of laparotomy benefits both surgeon and patient by allowing expeditious and informed action.

Upon radiographic examination, a 47-year-old male was found to have what appeared to be a single pedunculated polyp of the sigmoid colon. Colonoscopy revealed two sessile polyps in the splenic flexure in addition to the originally diagnosed lesion. At laparotomy, with the colonoscopic information at hand, the palpation of still another soft sessile polyp in the cecum made easier the decision to perform subtotal colectomy. The operative specimen contained a total of eight polyps, one of which contained an in situ carcinoma (Fig. 5).

Electrosurgical snares have been designed for transecting the stalk of a pedunculated polyp by using a combination of pressure and electrosurgical current. This can be accomplished safely, but dexterity and experience is required to assure complete removal of the polyp without inflicting damage upon the adjacent bowel wall. An electrosurgical scissor-type forcep, used principally for the removal of polyps with slender pedicles, has been developed by the author (Fig. 6).

While there have been reported instances of hemorrhage or perforation coincidental to polypectomy which necessitated laparotomy, innumerable procedures have been successfully done that attest to the general safety and applicability of the procedure. When colonoscopic polypectomy is contrasted with colotomy and polypectomy by laparotomy in terms of safety and comfort to the patient, expense of hospitalization and surgery, and time lost from gainful employment, the enormity of the advantages of colonoscopic polypectomy becomes evident.

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Summary

The flexible fiberoptic colonoscope has proven to be a significant advance in the diagnosis and management of colonic disorders. Although the colonoscope has proven to be an effective means of diagnosing and defining inflammatory lesions and neoplasms when barium enema studies are inconclusive, the most striking impact of this instrument has been on polypoid disease of the colon. The flexible fiberoptic colonoscope has provided an additional method of diagnosing polyps of the colon which compliments sigmoidoscopic and barium enema examinations. The capability of performing polypectomy without laparotomy is an advantage which defies measurement. Colonoscopy has added an important new dimension to the management of colonic disorders. □

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Wastebasket diagnosis

Degenerative arthritis of the hip

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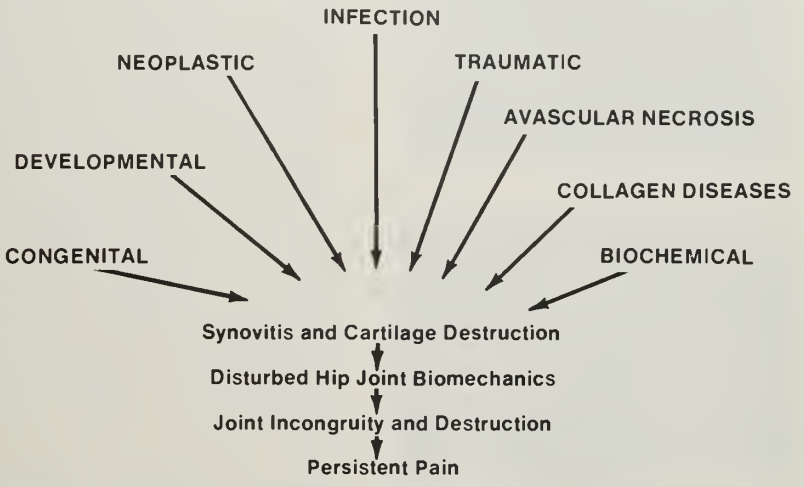
THE recent innovation of the total hip replacement has brought arthritis of the hip to the attention of the entire medical community. The patient presenting with a painful hip and X-ray changes of joint destruction is often said to have the diagnosis of DJD (degenerative joint disease) of the hip. This article seeks to clarify the various etiologies of arthritis of the hip and to delineate the appropriate treatment programs.

A critical evaluation of so-called degenerative arthritis of the hip reveals that there are, in fact, multiple etiologies for arthritis of the hip. The initial insult to the hip joint may arise from a disorder in any of the major disease categories. Several authors have noted that the congential, developmental, neoplastic, infectious, traumatic, collagen disease, and degenerative categories are represented as the initial injury to the hip. If the initial insult is inadequately treated, synovial inflammation, cartilage damage, and joint incongruity may result. (Fig. 1) This final common pathway of degenerative arthritis of the hip, therefore, may be a result of multiple etiologies. Careful evaluation of the clinical presentation and roentgenograms will often indicate the true etiology. A number of authors (Table I) have analyzed groups of patients as to the etiology of degenerative arthritis of the hip. In general, congenital subluxation, Perthes Disease, and slipped femoral capital epiphysis are the most common causes of secondary arthritis of the hip.

In the following outline we have classified arthritis of the hip into primary and secondary arthritis of the hip (Table II). The diagnosis of secondary arthritis of the hip refers to those patients who, after careful clinical laboratory and roentgenological evaluation, can be found to have arthritis of a definite

Figure 1
Final Common Pathway for Arthritis of the Hip



etiology. Primary arthritis of the hip refers to that form of articular damage that occurs without a specific identifiable factor. It is assumed that it results from "wear and tear." We will first consider those patients who present with secondary arthritis of the hip.

Congenital

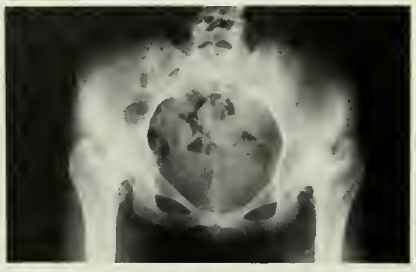
Although there has been great emphasis placed on the early diagnosis and treatment of congenital dislocation and subluxation of the hip, there still remains a significant number of patients who are symptomatic as a result of inadequate treatment. A residual mild subluxation may be asymptomatic in early adulthood but may become increasingly painful as the patient approaches middle age. Occasionally, a mild subluxation of the hip may have completely escaped careful scrutiny by the physician and may have received no treatment until the patient presents himself with sec-

TABLE I
Etiology of Arthritis of the Hip

Arthritis of the Hip		Gade 1947	Murray 1965	Lloyd Roberts 1955	Nicholl 1961	Adam 1958
Secondary Arthritis	Legg-Perthes Dis.	3.3%		2.4%	9.2%	5.3
	Congenital Subluxation	48	25%	21	31	21
	Slipped Femoral Capital Epiphysis	4.1	40%	6.5	6.2	5.3
	Other 2° causes	20		11	22	3.4%
Primary Arthritis		24%	35%	59%	59%	65%

Figure 2a.

Figure 2b.



ondary arthritis of the hip. Roentgenologically (Fig. 2, a and b) the indications of dysplasia of the hip are a lengthening of the femoral neck, increase in the thickness of bone along the medial aspect of this femoral neck (calcar), and varying degrees of lack of coverage of the femoral head by the acetabulum.

In general, the acetabulum will be angulated upward and found to have lost its downward curvature after reaching its apex. After articular damage appears, the patient often requires some form of arthroplasty of the hip. The changes usually are on the acetabulum as well as the femoral side of the joint; and, therefore, treatment of only one of these areas is usually a failure. The most effective treatment for this group of patients includes the osteotomy and vitalium mold arthroplasty. The total hip replacement is usually utilized for those patients over fifty-five years of age. If the disease is bilateral, the total hip replacement is done in the group under the age of fifty-five. The osteotomy generally is successful only in the early stages of hip arthritis.

Developmental

The developmental causes of arthritis of the hip may be defined as those conditions that appear clinically or radiologically during the period of epiphyseal activity. It is presumed that there is some genetic, familial, or constitutional predisposition to one of these conditions. The most common developmental disorders of the hip are Legg-Perthes disease and slipped femoral capital epiphysis. The chondrodystrophies and sickle cell anemia may also cause destruction of the hip in this early period of life. Legg-Perthes disease is basically a form of childhood avascular necrosis of the femoral head which undergoes a series of anatomical changes that often result in some permanent joint incongruity.

The slipped femoral capital epiphysis may occur as a result of a traumatic encounter but most commonly is not associated with a history of definite injury. It is probably related to weakness of the epiphyseal plate at the time of adolescent hormonal activity. This may also result in avascular necrosis of the femoral head, although late changes from the altered joint biomechanics is the most common sequela. Sickle cell anemia may present with avascular necrosis as a result of thrombosis of femoral head vessels and resultant oblitera-

Figure 3.

TABLE II

Classification of Arthritis of the Hip

I. Primary Arthritis of the Hip

"Wear and Tear" - no known etiology

II. Secondary Arthritis of the Hip

A. *Congenital*

Congenital dislocation and subluxation

B. *Developmental*

1. Legg Perthes Disease
2. Slipped Femoral Capital Epiphysis

C. *Neoplastic*

1. Benign bone lesions (e.g., osteoblastoma and chondroblastoma)
2. Pigmented villonodular synovitis

D. *Infections*

1. Acute septic arthritis (e.g., staph. & E. coli)
2. Subacute and chronic forms (e.g., E. coli urinary tract)
3. Tuberculosis

E. *Trauma*

1. Hip dislocations
2. Fracture acetabulum

F. *Avascular necrosis*

(e.g., previous femoral neck fracture)

G. *Collagen Diseases*

1. Rheumatoid arthritis
2. Ankylosing spondylitis

H. *Biochemical Abnormalities*

tion of the blood supply. The developmental causes of hip joint destruction usually do not result in significant joint destruction until the third or fourth decade. However, sometimes patients are quite symptomatic much earlier and, therefore, may require some form of treatment. Therapeutic measures for this group of patients must be highly individualized. They include the cup arthroplasty in the younger age group and the total hip replacement in the older age group.

Neoplasms

Occasionally benign neoplasms appearing in the femoral head, synovium, or acetabular area may present as degenerative arthritis of the hip. If the patient undergoes surgery at a younger age group for one of these lesions (e.g., villonodular synovitis, chondroblastoma, giant cell tumor of the femoral head, or a unicameral bone cyst of the acetabulum) it is possible for secondary arthritic changes to result. As a result of incongruity from earlier surgery, articular destruction of the joint may progress. This group of patients is one that also must be highly individualized in recommendations for treatment.

Infections

The hip joint may be "seeded" from a systemic infection. This may be either an acute presentation or a chronic, subacute, and repetitive insult. Any acute bacteremia (e.g., urinary tract, pulmonary, etc.) may result in this form of septic arthritis. In spite of careful treatment, it may later result in a persistent synovitis, cartilage destruction, incongruity of the joint, and resultant joint destruction. This is an inflammatory reaction on both sides of the joint; and if the process is a slow one, the hip may protude. Because of the danger of infection of total hip replacements, previous infection is a major contraindication to the total hip replacement. This group of patients has been successfully treated with debridement of the hip joint and insertion of a vitalium mold cup arthroplasty. An arthrodesis of the hip may also be considered in some instances.

Trauma

Arthritic change in the hip joint may result from posttraumatic avascular necrosis of the femoral head or fractures of the acetabulum which were not adequately reduced. Acetabular fractures of the hip (just as articular fractures elsewhere) must be reduced anatomically as soon as possible to prevent secondary posttraumatic arthritis. The incongruity and irregular joint surfaces cause eventual joint destruction. Femoral neck (intracapsular) fractures treated by internal fixation result in nonunion in 5-20 percent of the cases and have an incident of avascular necrosis up to 25-30 percent.

Avascular Necrosis

Avascular necrosis of the hip may result from a great number of metabolic and traumatic etiologies. The general metabolic and systemic causes include sickle cell disease, coagulation defects, Caisson's disease (nitrogen emboli following decompression), lupus erythematosus, and Gaucher's disease. Traumatic dislocations of the hip which remain unreduced for many hours, may present with avascular necrosis of the femoral head several months later.

The most common cause of avascular necrosis of the femoral head is the intracapsular fracture of the hip. Because of the precarious blood supply in fractures of this femoral neck, avascular necrosis of the femoral head may occur up to two years following the injury. Because of important therapeutic implications, the radiological findings of this lesion must be distinguished from other causes of degenerative joint disease of the hip. The femoral head appears dense on X-ray and shows no collapse early in the disease. However, if the condition progresses, collapse of the femoral head will lead to secondary joint changes with resultant severe persistent pain. Because of this difficulty, in the older age group fractures are treated by primary replacement with a femoral head prosthesis (Austin-Moore or Thompson). However, in those instances where the avascular necrosis becomes far advanced resulting in joint incongruity, more extensive surgery is required. It is difficult to obtain a successful arthrodesis of the hip with a poor blood supply of the femoral head. Vitalium mold cup arthroplasty in the younger patient

Figure 4.

Figure 5.

Figure 6a.

Figure 6b.

and the total hip replacement in the older age group (over fifty-five) have proven to be the procedures of choice for this group of patients.

Collagen Disease

Rheumatoid arthritis (Fig. 3) and the other collage vascular diseases often will present with arthritis of the hip. This persistent low grade synovitis results in a congruous erosion on the acetabular and femoral head sides of the hip joint. As a result of this concentric destruction, the roentgenogram will often demonstrate a protrusio acetabulum with advanced migration of the femoral head medially. Intrapelvic reaction new bone formation is common on X-ray. This group of patients is considered to have good results with the cup arthroplasty, but the total hip replacement in the older patient produces a much more dramatic and predictable result.

Biochemical Abnormalities

There is a great deal of research activity in this area in an attempt to identify various inborn errors of metabolism. One known disease is ochronosis. Homogentisic acid is deposited in the region of the cartilage and synovium. A synovitis occurs with resultant destruction and incongruity of the cartilage.

Primary Osteoarthritis

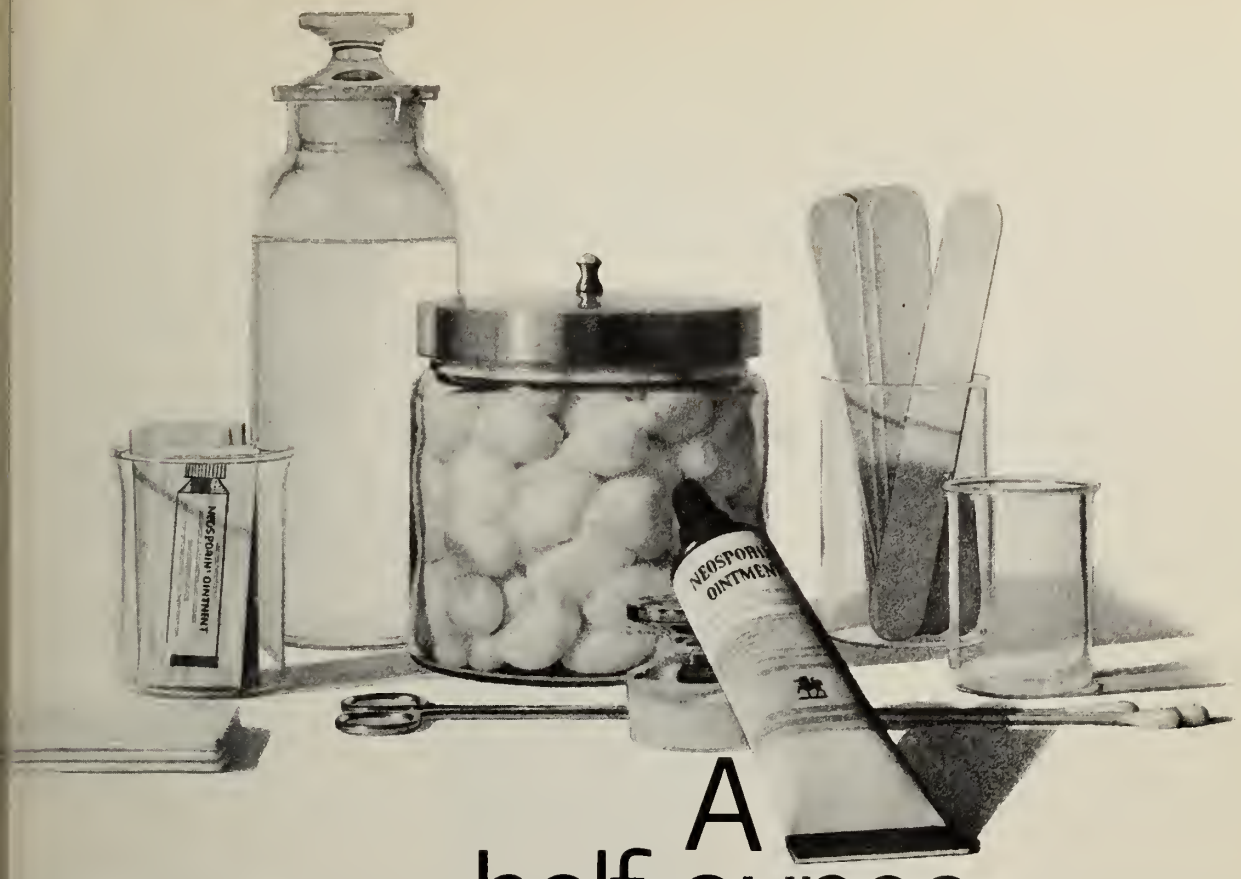
This large category is reserved for patients whose etiology cannot be identified. We, therefore, assume that it is on the basis of wear and tear. Most of these patients are in the sixty and seventy years age group and, therefore, are prime candidates for the total hip replacement (Fig. 4 and 5). The X-ray changes demonstrate the articular changes with a normally developed femoral head and acetabulum. There are multiple cysts and sclerotic areas on both sides of the hip joint. The biochemical changes associated with this form of hip arthritis have been studied extensively in the last few years. We, therefore, prefer to call this large group of hip disorders primary arthritis or primary osteoarthritis of the hip. This notes that no etiology is known today, but with continued research it is possible that many of these patients will some day fall into still another category of secondary arthritis of the hip.

Dr. Berman is associate professor of the division of orthopedic surgery in the department of surgery at Hahnemann Medical College and Hospital, Philadelphia.

Primary osteoarthritis of the hip in the older patient represents the most common indication for the total hip replacement. Unilateral cases are considered candidates for this procedure if they are under fifty-five years of age. Bilateral cases must be carefully individualized and, in general, they are done at a younger age. The main contraindication is previously known or suspected infection. We utilize the Charnley-Mueller total replacement (Fig. 6, a and b). The acetabulum is high-density polyethylene (a molecular weight of about one million), and the femoral component is vitalium (an alloy of cobalt, chromium, molybdenum). Methyl Methacrylate, a self-curing acrylic, is used as a bone cement to assist in fixation of the metallic implant to bone. The total hospitalization time for patients undergoing the total hip replacement is usually two or three weeks. The operation clearly represents one of the great surgical advances of the last decade.

Summary

We have reviewed the various etiologies of arthritis of the hip. They may be divided into primary arthritis of the hip and secondary arthritis of the hip. The final common pathway for destructive arthritis of the hip was presented. Careful analysis of patients with degenerative joint disease of the hip will often reveal the true etiology. This evaluation is important because it will assist in the decision of the specific operation. We have found that the total hip replacement has been a dramatic and predictable operation for many patients with arthritis of the hip. □



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The Role of the Detail Man

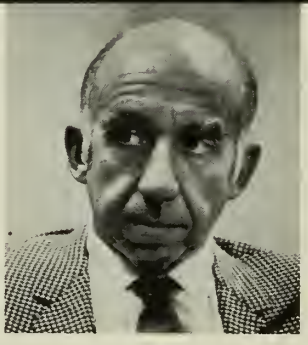
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date informnation about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

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Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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trauma

Treating wringer injuries

WILLIAM P. GRAHAM, III, M.D. THOMAS S. DAVIS. M.D.
STEPHEN H. MILLER, M.D. JOHN C. SCHANTZ, M.D.

Hershey

Figure 1 A: Young male with wringer type injury of the hand and forearm shortly after injury.

Figure 1 B: Decompression of skin and fascial envelope of forearm and hand.

The gradual replacement of the old fashioned wringer type washing machines has fortunately diminished the occurrence of forearm injuries from these machines. The agitators of the newer washing machines are capable of inflicting injury but usually to a lesser degree than that sustained in the old style machines.

The acute injury experienced may be simple or complex, open or closed, but is most often deceptively innocuous in its initial stages. The arm caught in a wringer is usually drawn through until a site too large to negotiate the space between the rollers is encountered. Typically such obstructions occur at the wrist, the elbow and the axilla. Often the roller remains engaged and a friction burn accompanies the crushing injury.

The shearing forces produced by the roller tear the skin and subcutaneous tissue free from the underlying fascia and muscle. Hemorrhage deep to the fat with ischemia and later swelling impairing venous return results (Fig. 1A-C).

Full thickness friction burns are produced at the final point of impingement of the rollers (Fig. 2). Traction on the axillary neurovascular pedicle or shoulder can produce neuropraxia or neurotmesis. If massive engorgement due to interstitial hemorrhage and diminished venous return increases, a Volkmann's contracture can result. Decompressing skin incision and fascial splitting may be needed to avoid muscular necrosis. Even with adequate early decompression late fibrosis, restricted function and neurological deficits (tardy ulnar palsy) may occur.

The early appearance of a wringer injury may be deceptive. Swelling and discoloration may develop insidiously and the extent of the full thickness skin loss may not be apparent. Roentgenograms will be required

Figure 1 C-E: Wounds after mesh grafting with autograft skin.

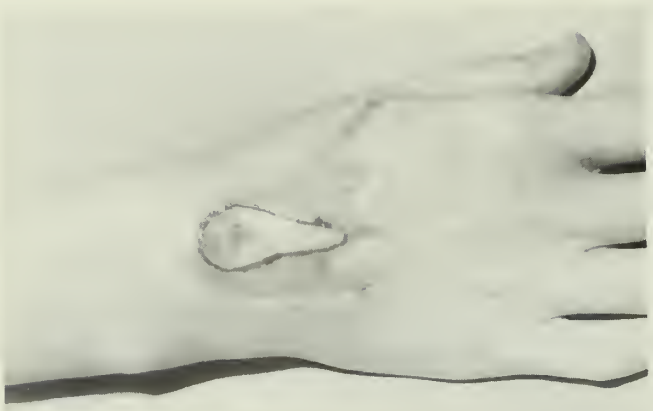

Figure 2: Friction burn on dorsum of hand of a young woman who caught her hand between two rollers at work. Methylene blue outlines the area of maximum injury.

to evaluate skeletal injuries. The development of unremitting throbbing pain is cause for alarm and signals the occurrence of ischemia. Occasionally if sensation is diminished this sign may not occur. Cyanosis and impaired capillary circulation may be evident until the deep muscular swelling is relieved by surgical decompression.

The initial evaluation of an extremity injured by the compressing, shearing forces of a wringer should include notations regarding: 1) swelling, 2) capillary circulation, 3) nature of the pain or lack thereof, 4) color, 5) sensation, and 6) mobility. The extremity should be cleansed and immediately elevated, preferably without suspension. If suspension is required a tubular stockinette should be partially split and the cut slips tied under the opposite axilla allowing the injured part to be supported within the stockinette sleeve that is attached to an overhead frame. The hand should be splinted in the position of function with the thumb abducted and slightly pronated. The hand should be inspected at least every other hour and the above features reevaluated. Antibiotics are administered when the injury is massive or the skin loss is great.

If there are open injuries debridement is done, and a loose closure, often with porous paper strips, is applied. It is often best to excise a reverse based flap and to graft the bed. As the swelling subsides, gradual mobilization, often within the whirlpool, is started. Fasciotomy wounds may be grafted with moderate thickness meshed grafts to hasten their healing once the acute phase of swelling is over. Allografts or biological membranes (amnion) may be employed to protect these open wounds until they are autografted.

The deep injury to the muscles with hemorrhage into confined spaces and attendant swelling may follow wringer injuries. Full thickness skin avulsion can be treated by early grafting with meshed grafts. Friction burns may have to be excised and grafted also. The hazards of impaired circulation and a subsequent Volkmann's contracture must be constantly acknowledged.

The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services cooperate in the dissemination of information on trauma. This paper was prepared by the department of surgery of the Milton S. Hershey Medical Center.

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General Practitioners—needed in Tyrone, Pa. Located in Central Pennsylvania, 25 miles from Penn State University. Privileges available at JCAH approved hospital with good specialty backup—unlimited recreational facilities—cooperative banking—office space available adjacent to Hospital. Contact Daniel M. Friday, M.D., Tyrone Hospital, Tyrone, Pa. 16686. Telephone: (814) 684-1255.

Accident Ward Physician—full time—for Delaware County Memorial Hospital, Drexel Hill, Pa. 19026. Pa. licensed. Liberal income guarantee. Call or write President. Clearbrook 9-3800.

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obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Chester H. Albright, Jr.,** Harleysville; Hahnemann Medical College, 1938; age 62; died October 31, 1974. Survivors include his wife, a son, and a sister.

• **Arthur E. Billings,** Philadelphia; North Carolina Medical College, 1904; age 90; died April 13, 1974. There is no information regarding survivors.

• **Lachlan M. Cattanach,** Kingston; Johns Hopkins University School of Medicine, 1925; age 74; died October 4, 1974. He had been retired after serving thirty-five years as a surgeon. He was a past president of the Luzerne County Medical Society. Dr. Cattanach is survived by his wife; a son; two daughters; and a brother, George S. Cattanach, M.D., New York City.

• **Henry C. Dirlam,** Honesdale; State University of New York, Downstate Medical Center, 1923; age 77; died November 4, 1974. He had practiced medicine for over fifty years. He is survived by his wife, a daughter, and a son.

• **John P. Emich, Jr.,** Philadelphia; Temple University School of Medicine, 1943; age 57; died October 13, 1974. He was director of professional services at Philadelphia General Hospital and clinical professor of obstetrics and gynecology at the University of Pennsylvania School of Medicine. He is survived by his mother.

• **Marie A. S. Howard,** Secane; Medical College of Pennsylvania, 1909, age 89; died May 29, 1974. No information regarding survivors is available.

• **William B. Lewis,** Shamokin; University of Pennsylvania School of Medicine, 1930; age 70; died October 9, 1974. He is survived by his wife and a son.

• **William K. McBride,** Linglestown; University of Pennsylvania School of Medicine, 1926; age 73; died October 11, 1974. He was coordinator of the surgical department and chairman of the medical directorate at Polyclinic Hospital prior to his retirement in 1967. He is survived by his wife.

• **John A. O'Donnell,** Pittsburgh; Jefferson Medical College, 1920; age 77; died October 14, 1974. He is survived by his wife and a son.

• **Ernest Oehl,** Philadelphia; University of Vienna, Austria, 1924; age 74; died October 3, 1974. He had practiced medicine for over fifty years. His wife and a sister survive him.

• **Donald R. Pohl,** Johnstown; Jefferson Medical College, 1955; age 47; died November 1, 1974. He was the incoming president of the Cambria County Medical Society. Dr. Pohl was a fellow of the American Academy of Pediatrics. He is survived by his wife, two daughters, and a son.

• **Ella I. Rynkiewicz-Summa,** Shenandoah; Women's Medical College (now Medical College of Pennsylvania) 1915; age 90; died September 28, 1974. She had practiced medicine for over fifty years. There are no immediate survivors.

• **Harold I. Sparling,** Chambersburg; University of Michigan School of Medicine, 1923; age 78; died October 12, 1974. He had been post surgeon at Letterkenny Army Depot prior to his retirement eight years ago. He is survived by his wife, two daughters, and two sisters.

• **Paul A. Sica,** Pittsburgh; Jefferson Medical College, 1931; age 67; died September 30, 1974. He had been medical director of St. Francis General Hospital and the Pittsburgh Academy of Medicine, later becoming medical director of St. Clair Memorial Hospital. He was a member of the American College of Chest Physicians and the American College of Cardiology. Survivors include his wife; three daughters; two sons, one of whom is Paul A. Sica, M.D., Pittsburgh; four sisters; and four brothers.

• **Robert S. Totten,** Pittsburgh; University of Pittsburgh School of Medicine, 1946; age 52; died September 8, 1974. He was a member of the American Association for Cancer Research, the International Academy of Pathology, the American Society of Clinical Pathologists, and the College of American Pathologists. He is survived by two sons.

• **William A. Van Saun,** Mahanoy City; Hahnemann Medical College, 1943; age 58; died October 24, 1974. He was Schuylkill deputy coroner. He is survived by his wife, a daughter, two sons, and two sisters.

• **Arthur D. Waltz,** Lansdowne; University of Pennsylvania School of Medicine, 1916; age 90; died November 4, 1974. Dr. Waltz had been director of pathology at Delaware County Memorial Hospital for thirty years prior to his retirement in 1957. He was a fellow of the American Society of Clinical Pathologists.

Howard R. Buckley, Liberty; University of Toronto Medical College, 1924; age 75; died June 3, 1974. His widow survives him.

Marcella A. Helsel, Pittsburgh; University of Pittsburgh School of Medicine, 1928; age 69; died October 4, 1974. Surviving are a son, Eugene Helsel, Jr., M.D., Doylestown; a daughter; and two sisters.

Harry F. Hoffman, Seagirt, New Jersey; Hahnemann Medical College, 1906; age 89; died October 28, 1974. He was a former superintendent at Allentown State Hospital. He was a diplomate of the American Board of Psychiatry and Neurology, a fellow of the American Psychiatric Association, and a member of the Congress of Physical Therapy. He is survived by his wife, a son, and five brothers.

Leonard J. Thompkins, Jenkintown; Jefferson Medical College, 1960; age 39; died September 26, 1974. He was an associate pathologist at Mercy Catholic Medical Center. His mother survives him.

Arthur Mirsky, Los Angeles, Cal.; McGill University College of Medicine, 1931; age 67; died September 16, 1974. He was formerly university professor of clinical sciences at the University of Pittsburgh School of Medicine and a Veterans Administration Distinguished Physician.

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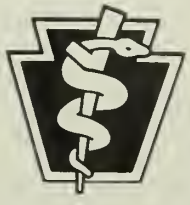

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(representing: American Heart Association, Pennsylvania Affiliate); Polyclinic Hospital, Harrisburg, Pennsylvania 17105

Richard K. Snyder, D.O.
(Physician Actively Involved in a Community Osteopathic Hospital Educational Program); Allentown Osteopathic Hospital, 1736 Hamilton Street, Allentown, Pennsylvania 18104

Richard Swavely, Ed.D.
(representing: Pennsylvania State University Continuing Education); Assistant Director, Continuing Education, Pennsylvania State University, 501 J. Orvis Keller Building, University Park, Pennsylvania 16802

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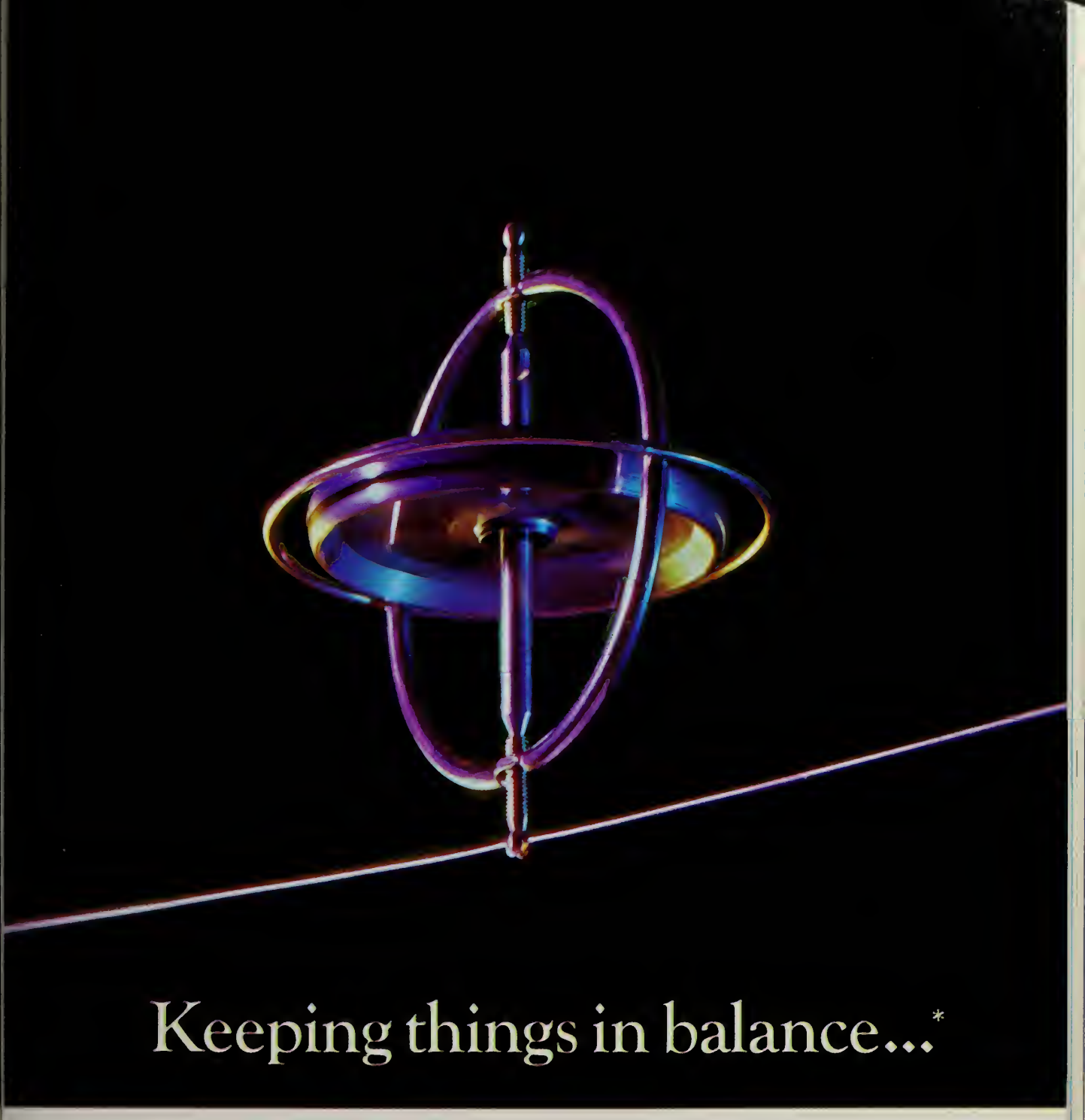
(representing: Greater Delaware Valley Regional Medical Program); Greater Delaware Valley Regional Medical Program, 551 West Lancaster Avenue, Haverford, Pennsylvania 19041

Charles M. Worrell, D.O., *Secretary*
(Physician Actively Involved in a Community Osteopathic Hospital Educational Program); Community General Osteopathic Hospital, 4300 Londonderry Road, Harrisburg, Pennsylvania 17109

Staff Assignment—**LeRoy C. Erickson**



Keeping things in balance...*

Antivert®/25 Tablets
(25 mg. meclizine HCl)

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

ROERIG Pfizer

A division of Pfizer Pharmaceuticals
New York, New York 10017

Take your C.M.E. by the sea ....

49 Continuing Medical Education courses at AMA's Annual Convention, June 14-18, 1975 Atlantic City, New Jersey

Those 49 Category I Continuing Medical Education courses are the largest number ever offered at an AMA convention. On top of that, there'll be Category I symposia and medical motion pictures on a wide variety of specialties.

Also featured are a number of special interest programs: a two-day session on the Medical Aspects of Sports, a series of special courses on clinical pathology, and a joint program by the American Veterinary Medical Association and the AMA on diseases transmitted to man by household pets. Physicians' wives and families will be offered interesting programs co-sponsored by the AMA's Council on Scientific Assembly and the Woman's Auxiliary of the AMA.

For more information, write:
Dept. of Circulation & Records, AMA,
535 N. Dearborn St., Chicago, IL 60610.

Atlantic City

Pennsylvania Guide to Continuing Medical Education

prepared by: PENNSYLVANIA MEDICAL
Continuing Education Institute
20 Erford Road Lemoyne, Pennsylvania 17043
(717) 238-1635

This list of continuing medical education announcements is published as a supplement to the September and January issues of PENNSYLVANIA MEDICINE. It includes all intermittent programs, courses, seminars, lectures, and other continuing medical education activities that were reported prior to the deadline. Items received after the deadline will be published (if presentation date has not passed) in the next supplement. For a reprint of this supplement or for submitting additional announcements, contact the Pennsylvania Medical Continuing Education Institute at the address shown above.

In most cases, each of the continuing medical education activities listed in this supplement has been granted AAFP and ACGP (osteopathic) credit. Contact those offices for details.

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General Abbreviations:

Acad	Academy
Admin	Administrator
Amer	American
Assn	Association
Ave(s)	Avenue(s)
Bd	Board
Blvd	Boulevard
Bldg	Building
Cntr	Center
Clin	Clinic, Clinical
Co	County
Coll	College
Comm	Committee
Cmsn	Commission
Cont	Continuing
CME	Continuing Medical Education
Dept	Department
Dir	Director
DME	Director Medical Education
Dist	District
Div	Division
Dr	Drive
E	East
Educ	Education
Exec	Executive
Gen	General
Grad	Graduate
Hosp	Hospital
Inst	Institute
Lab(s)	Laboratory, Laboratories
Med	Medical, Medicine
Mem	Memorial
Natl	National
N	North
Pkwy	Parkway
Phys	Physicians
Pa	Pennsylvania
Box	Post Office Box
Prac	Practice
Prof	Professional
Prgm	Program
RMP	Regional Medical Program
Rehab	Rehabilitation
Rd	Road
Rm	Room
Sch	School
Secy	Secretary
Serv	Service
Soc	Society
S	South
St	State, Street, Saint
Surg(s)	Surgeon(s)
Univ	University
VA	Veterans Administration
W	West

REFERENCE CODE FOR ACCREDITED PENNSYLVANIA INSTITUTIONS
(Each of the following institutions has continuing medical education accreditation to grant Category One credit.)
Note: When any of these names appear in individual announcements, the code name (rather than full name) is printed. Refer to this section for address.

ACP—Amer. Coll. of Phys., 4200 Pine St., Philadelphia 19104
ACS—Amer. Coll. of Surgs., 55 E. Erie St., Chicago, Ill. 60611
AHA—Amer. Heart Assn., Pa. Affiliate, P.O. Box 2435, Harrisburg 17105
Allegheny—Allegheny Gen. Hosp., 320 E. North Ave., Pittsburgh 15212
Allergy—Pa. Allergy Assoc., 240 N. 36th St., Camp Hill 17011
AMA—Amer. Med. Assn., 535 N. Dearborn St., Chicago, Ill. 60610
Anesthesiologists—Pa. Soc. of Anesthesiologists, 20 Erford Rd., Lemoyne, 17043
Chestnut Hill—Chestnut Hill Hosp., 8835 Germantown Ave., Philadelphia 19118
Clin. Path.—Pa. Assn. of Clin. Path., 1735 W. Main St., Norristown 19401
Coatesville VA—Coatesville Vet. Admin. Hosp., Coatesville 19320
Colon and Rectal—Pa. Soc. of Colon and Rectal Surg., Liberty Sq. Med. Cntr., 17th and Liberty Sts., Allentown 18104
Conemaugh—Conemaugh Valley Memorial Hosp., 1086 Franklin St., Johnstown 15905
Delaware Co.—Delaware Co. Mem. Hosp., Lansdowne Ave., Drexel Hill 19026
Dermatology—Pa. Acad. of Dermatology, 8220 Castor Ave., Philadelphia 19152 (c/o Charles H. Greenbaum, M.D.)
Elwyn—Elwyn Institute, 111 Elwyn Rd., Elwyn 19063
EPPI—Eastern Pa. Psychiatric Institute, Henry Ave. and Abbottsford Rd., Philadelphia 19129
Frankford—Frankford Hosp., Frankford Ave. and Wakeling St., Philadelphia 19124
Geisinger—Geisinger Med. Cntr., Danville 17821
Hahnemann—Hahnemann Med. Coll., 230 N. Broad St., Philadelphia 19102
Harrisburg—Harrisburg Hosp., Harrisburg 17101
M. S. Hershey—Pa. State Univ. Coll. of Med., M. S. Hershey Med. Cntr., Univ. Dr., Hershey 17033
Institute—Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139
Jeanes—Jeanes Hosp. of Fox Chase Center for Cancer and Med. Sciences, 7600 Central Ave., Philadelphia 19111
Jefferson—Jefferson Med. Coll. 1025 Walnut St., Philadelphia 19107
Lebanon VA—Lebanon Vet. Admin. Hosp., Lebanon 17042
Lehigh AHEC—Lehigh Valley Area Health Ed. Cntr., 335 N. Eighth St., Allentown 18102
MCP—Med. Coll. of Pa., 3300 Henry Ave., Philadelphia 19129
Mercy/Pgh.—Mercy Hosp., Pride & Locust Sts., Pittsburgh 15219
Norristown State—Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19141
Packer—Robert Packer Hosp., Sayre 18840
PAFP—Pa. Acad. of Family Phys., 5600 Derry St., Harrisburg 17111
Paoli—Paoli Mem. Hosp., Paoli 19301
PAO&O—Pa. Acad. of Oph. & Otol., 232 N. 5th St., Reading 19601
PMS—Pa. Med. Society, 20 Erford Rd., Lemoyne 17043
Phoenixville—Phoenixville Hosp., 140 Nutt Rd., Phoenixville 19460
Polyclinic—Harrisburg Polyclinic Hosp., Third St. and Polyclinic Ave., Harrisburg 17105
Psychiatry—Pa. Psychiatric Soc. 20 Erford Rd., Lemoyne 17043
Radiology—Pa. Radiological Soc., 20 Erford Rd., Lemoyne 17043
Reading—Reading Hosp., 6th Ave. & Spruce St., Reading 19602
St. Francis—St. Francis Gen. Hosp., Penn Ave. and 45th St., Pittsburgh 15201
St. Margaret—St. Margaret Mem. Hosp., 265-46th St., Pittsburgh 15201
Temple—Temple Univ. Sch. of Med., 3400 N. Broad St., Philadelphia 19140
U. of Pa.—Univ. of Pa. Sch. of Med., 288 Med. Labs Bldg., Philadelphia 19174
Pitt—Univ. of Pittsburgh Sch. of Med., 1022-H Scaife Hall, Pittsburgh 15261
Roentgen Ray—Phila. Roentgen Ray Soc., Temple U. Health Sciences Cntr., Philadelphia 19140
Warren State—Warren St. Hosp., Box 249, Warren 16365
Washington—Washington Hosp., 155 Wilson Ave., Washington 15301
West Penn—Western Pa. Hosp., 4800 Friendship Ave., Pittsburgh 15224
York—York Hosp., George St. & Rathton Rd., York 17405

PENNSYLVANIA MEDICAL CONTINUING EDUCATION INSTITUTE

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(representing: The Hospital Association of Pennsylvania); York Hospital, George Street and Rathton Road, York, Pennsylvania 17405

John H. Killough, Ph.D., M.D.
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(representing: Pennsylvania Department of Health); Pennsylvania Department of Health, Room 832, Health and Welfare Building, Harrisburg, Pennsylvania 17120

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(representing: Public at Large); Academic Vice President, Gannon College, Erie, Pennsylvania 16501

David A. Smith, M.D.
(representing: American Heart Association, Pennsylvania Affiliate); Polyclinic Hospital, Harrisburg, Pennsylvania 17105

Richard K. Snyder, D.O.
(Physician Actively Involved in a Community Osteopathic Hospital Educational Program); Allentown Osteopathic Hospital, 1736 Hamilton Street, Allentown, Pennsylvania 18104

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(representing: Pennsylvania State University Continuing Education); Assistant Director, Continuing Education, Pennsylvania State University, 501 J. Orvis Keller Building, University Park, Pennsylvania 16802

Charles M. Worrell, D.O., *Secretary*
(Physician Actively Involved in a Community Osteopathic Hospital Educational Program); Community General Osteopathic Hospital, 4300 Londonderry Road, Harrisburg, Pennsylvania 17109

Vacancy
(Member of the Public Whose Daily Activities are Relative to Work of this Organization)

ANNOUNCEMENTS

For more information, such as: frequency of sessions, fees, maximum registration, faculty, etc., contact the director at the address given in the announcement or in the REFERENCE CODE box on the cover:

Abington Mem. Hosp.; Jan. 21 - Feb. 18, 1975
(1) Newer Diagnostic Techniques - How to and When to Use; by **Temple**. (75-1-5)
Contact: W. Bernard Kinlaw, M.D., Dir. Med. Dept., Abington Mem. Hosp., 1200 York Rd., Abington 19001

Allentown Hosp. Assn.; '74-'75 Academic Year
(1) Continuing Education Program; by **U. of Pa.**; bi-monthly at Allentown Hosp., Sacred Heart Hosp., and Allentown-Sacred Heart Hosp. Cntr. (75-1-367)
Contact: Aaron D. Freedman, M.D., Assoc. Dean, U. of Pa.
(1) Multidisciplinary Tumor Conference; by **Lehigh AHEC**; monthly (75-1-368)
Contact: Nathaniel Silon, M.D.
(1) General Practice Conferences; by **Lehigh AHEC**; monthly (75-1-369)
Contact: James R. Clifford, M.D.
(1) Clinical Medical Conference; by **Lehigh AHEC**; weekly (except Second Tuesday) (75-1-370)
Contact: Dean Dimick, M.D.
(1) Seminars in Neurology; by **Lehigh AHEC**; monthly (75-1-371)
Contact: Lawrence Levitt, M.D.
(1) Combined Medical and Orthopedic Rheumatology Conference; by **Lehigh AHEC**; bi-monthly (75-1-372)
Contact: Barre Kaufman, M.D.
(1) OB-GYN Conference; by **Lehigh AHEC**; weekly (75-1-373)
Contact: Joseph Miller, M.D.
(1) Surgical Conference; by **Lehigh AHEC**; weekly (75-1-374)
Contact: Donald Gaylor, M.D.
(1) Painful Hand; by **Lehigh AHEC**; at Allentown-Sacred Heart Hosp. Cntr.; Apr. 12, 1975 (75-1-375)
Contact: Allan E. Trevaskis, M.D.
All contacts at: Allentown Hosp. Assoc.; 17th and Chew Sts., Allentown 18102

Allentown and Sacred Heart Hosp. Cntr.; '74-'75 Academic Year
(1) Continuing Education Program; by **U. of Pa.**; bi-monthly, Sept. 18-May 21 (75-1-294)
(1) Painful Hand; by **Lehigh AHEC**; Apr. 12, 1975 (75-1-375)
Contact: Fred D. Fister, M.D., DME, Allentown & Sacred Heart Hosp. Cntr., 1200 S. Cedar Crest Blvd., Allentown 18105

Allentown; Sacred Heart Hosp.; '74-'75 Academic Year
(1) Visiting Lectureship Program; by Allentown Phys. Anesthesia Assoc., Inc. and **U. of Pa.** 3 times monthly, 8 months (75-1-210)
Contact: Ramon J. Deeb, M.D., Dir. of Educ., APAA, Inc., 421 Chew St., Allentown 18102
(1) Continuing Education Program; by **U. of Pa.**, bi-monthly at Allentown Hosp., Sacred Heart Hosp. and Allentown-Sacred Heart Hosp. Cntr. (75-1-367)
Contact: Aaron D. Freedman, M.D., Assoc. Dean, U. of Pa.

Aliquippa; Sept. 18, 1974 - May 21, 1975
(1) Continuing Education for Physicians; by **Pitt.**; alternately at Beaver Co. and Aliquippa Hosps., Third Wednesdays (75-1-119)
Contact: Mrs. Susan Frey, Exec. Secy., Beaver Co. Med. Soc., 350 Adams St., Rochester 15074

Altoona Hosp.; '74-'75 Academic Year
(1) A Continuing Medical Education Program; by **M.S. Hershey** and **Jefferson**; First and Third Thursdays (75-1-39)
Contact: Robert L. Barenberg, M.D., DME, Altoona Hosp., Howard Ave. and Seventh St., Altoona 16603

Key to symbols:
( ) Numbers in parentheses at the beginning of an announcement indicate the PRA Category number in which attendance at this program should be reported. You may report each hour of attendance.
(75-1-XX) Numbers in parentheses at the end of an announcement are code numbers which will be helpful as a cross reference from the Subject Index section of this supplement.
Bold Face Type indicates an institution that has Category One accreditation. This name MUST APPEAR on your PRA APPLICATION to the AMA if you are to receive Category One credit.

Bedford; May 22-24, 1975
(1) Annual Conference - **PAO&O** (75-1-6)
Contact: Donald Kamerer, M.D., Secy., PAO&O.

Bethlehem, St. Luke's Hosp.; '74-'75 Academic Year
(1) Important Topics in Internal Medicine; by **Lehigh AHEC** and **MCP**; monthly, Sept-June (75-1-49)
Contact: William R. Thompson, M.D., Chief, Dept. of Med., St. Luke's Hosp., 801 Ostrum St., Bethlehem 18015
(1) Important Topics in Obstetrics and Gynecology; by **Lehigh AHEC** and **MCP**; monthly Oct. - June (75-1-50)
Contact: Frank S. Flor, M.D., Chief, Dept. of Ob/Gyn, St. Luke's Hosp., 801 Ostrum St., Bethlehem 18015
(1) Important Topics in Psychiatry; by **Lehigh AHEC** and **MCP**; monthly, Oct-June (75-1-51)
Contact: Leon A. Skweir, M.D., Dept. of Psych., M.C.P.

Bridgeville; Mayview State Hosp.; June 11, 1974 - Mar. 11, 1975
(1) Continuing Education for Physicians; by **Pitt.**; second Tuesdays (75-1-110)
Contact: Robert Trivus, M.D., Superintendent, Mayview St. Hosp., Bridgeville 15017

Bristol; Sept. 3, 1974 - June 2, 1975
(1) Program of Continuing Medical Education; at Lower Bucks Hosp.; by **PAFP.** (75-1-40)
Contact: Administrator, Lower Bucks Hosp., Bath Rd. @ Route 13, Bristol 19007.

Bryn Mawr Hosp.; '74-'75 Academic Year
(1) Correlated Clinical Science Course/Medicine; by **Jefferson**; monthly (except Feb.) Oct.-May (75-1-350)
(1) Correlated Clinical Science Course/Pediatrics; by **Jefferson**; monthly, Oct.-May (75-1-352)
(1) Correlated Clinical Science Course/Psychiatry; by **Jefferson**; bi-monthly, Oct.-June (75-1-353)
(1) Correlated Clinical Science Course/Surgery; by **Jefferson**; monthly, Oct.-May (75-1-351)
Contact: Theodore J. Berry, M.D., DME, Bryn Mawr Hosp., Bryn Mawr 19010
(1) Main Line Medical Conference; at Sheraton-Valley Forge; by **Jefferson** May 1-3 (75-1-296)
Contact: Harold J. Robinson, M.D., Chrm., Main Line Med. Conf., Bryn Mawr Hosp., Bryn Mawr 19010

Butler; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; monthly, Sept-June (75-1-111)
Contact: S. A. Nallathambi, M.D., Prgm. Chrm., Butler Co. Med. Soc., 230 S. Washington St., Butler 16001

Camp Hill; May 2-4, 1975
(1) Annual Meeting of **Anesthesiologists** at Penn Harris Motor Inn (75-1-297)
Contact: James C. Erickson, III, M.D., Chrm., Cmte. on Cont. Educ., Anesthesiologists

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Camp Hill; Radiology; '74-'75 Academic Year
(1) Southcentral Pa. Area Radiologic Conference (SPARC); at Penn Harris Motor Inn; by **Radiology** and **M.S. Hershey**; 1st Thursdays each month Sept.-June (75-1-298)
Contact: Theodore A. Tristan, M.D., Secy., Radiology

Canonsburg Gen. Hosp.; Sept. 10, 1974 - May 6, 1975
(1) Continuing Education for Physicians; by **Pitt**; monthly (75-1-112)
Contact: Louis Signorella M.D., Canonsburg Gen. Hosp., Canonsburg 15317

Carnegie; Woodville St. Hosp.; 1975
(1) Continuous Education Seminar; by **Pitt**; every Tuesday, Feb. 4-Nov. 4 (75-2-1)
Contact: Maurice S. Cerul, M.D., Div. of Educ., Woodville St. Hosp., Carnegie 15106

Charleroi; Sept. 17, 1974 - Feb. 18, 1975
(1) Continuing Education for Physicians; by **Pitt**; alternately at Charleroi Div. and Monongahela Div., Monongahela Valley Hosp. (75-1-41)
Contact: U.A. DeRienzo, M.D., Charleroi Div., Monongahela Valley Hosp., Inc., Charleroi 15022

Chester; Sept. 10, 1974 - May 27, 1975.
(1) Continuing Education Program; at Crozer-Chester Med. Center; by **Hahnemann** (75-1-92)
Contact: Robert J. Schaefer, Exec. Dir., Cont. Educ., Hahnemann

Danville; **Geisinger**, '74-'75 Academic Year
(1) Cardiovascular Conference; Wednesdays (75-1-95)
(1) Cardiac Rehabilitation; May 20, 1975 (75-1-304)
(1) Cardiac Electrophysiology Conference; Fridays (75-1-97)
(1) Dermatology Conference; Daily (75-1-98)
(1) Esophageal Disorders; Mar. 12, 1975 (75-1-299)
(1) Goiter Differential Diagnosis and Treatment; Apr. 30, 1975 (75-1-300)
(1) Office Management of Diabetes; Feb. 12, 1975 (75-1-301)
(1) Neurologic Problems in Family Practice; Apr. 2, 1975 (75-1-302)
(1) Clinical Assessment of the Cell Mediated Immune System; Mar. 7, 1975 (75-1-303)
(1) Advances in Internal Medicine; Second Wednesdays (75-1-101)
(1) Advances in Medical Pharmacy and Therapeutics; Fourth Wednesdays (75-1-102)
(1) Hospital Grand Rounds; Fridays (75-1-103)
(1) Medical Clinical Pathologic Conference; First Wednesdays (75-1-100)
(1) Montour Co. Med. Soc. Visiting Professor Program; Third Mondays (75-1-108)
(1) Neurology-Neurosurgery Conference; Mondays (75-1-105)
(1) Primary Caesarian Section Review; Third Tuesdays (75-1-93)
(1) Head and Neck Tumor Conference; Mondays (75-1-106)
(1) Multidisciplinary Tumor Conference; First and Third Tuesdays (75-1-107)
(1) 7th Annual Conference—Special Child-Behavior Problems; May 3, 1975 (75-1-305)
(1) Pediatric Grand Rounds; Second and Fourth Tuesdays (75-1-104)
(1) Pediatric Perinatal Conference; Third Thursdays (75-1-94)
(1) Pediatric Teaching Conference; Tuesdays and Thursdays (75-1-96)
(1) Rehabilitation Medicine Teaching Program; Thursdays (75-1-99)
Contact: Mildred K. Fleetwood, Ph.D., Secy., Educ. Cmte., Geisinger

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DuBois; DuBois Hosp.; Winter '75
(1) Continuing Education for Physicians; by **Pitt**. and Jefferson Co. Med. Soc.; weekly (75-1-136)
Contact: W. G. Lundgren, M.D., Deposit Natl. Bank Bldg., DuBois 15801

Easton Hosp.; '74-'75 Academic Year
(1) Continuing Education Program; by **Hahnemann**; Oct. 2 - June 4 (75-1-10)
Contact: Robert J. Schaefer, Exec. Dir., Cont. Educ., Hahnemann
(1) Psychiatric Luncheon Conference; by **Hahnemann**; monthly, Sept. 23-June 16 (75-1-217)
Contact: Richard E. Hicks, M.D., Dept. of Mental Health Sciences, Hahnemann.

Franklin Hosp.; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; alternately at Franklin, Oil City and Titusville Hosps. (75-1-113)
Contact: Robert M. Pilewski, M.D., Venango Co. Med. Soc., 9 Glenview Ave., Oil City 16301

Hanover Gen. Hosp.; '74-'75 Academic Year
(1) Continuing Education; by **M.S. Hershey**; monthly (75-1-295)
Contact: Gabriel Zelesnick, M.D., Chrm., Cont. Educ., Hanover Gen. Hosp., 300 Highland Ave., Hanover 17331

Harrisburg; Blood Banks; Apr. 25-26, 1975
(1) 18th Annual Lectureship of Pa. Assoc. of Blood Banks; at Host Inn; by **Clin. Path.** (75-1-306)
Contact: L. M. Tanner, M.D., Secy.-Treasurer, Pa. Assoc. of Blood Banks, 1551 Rita Lane, Lebanon 17042

Harrisburg; **Harrisburg**; '74-'75 Academic Year
(1) Continuing Education for Family Practitioners; monthly Sept. - Apr.; alternately at **Harrisburg** and **Polyclinic** Hosps. (75-1-124)
(1) Problems in Medicine; weekly (75-1-125)
(1) Keep Sharp in Surgery; one day alternate weeks (75-1-126)
(1) Medical Grand Rounds; Tuesdays (75-1-127)
Contact: Thomas F. Fletcher, M.D., Dir. of Med. Affairs, Harrisburg

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Harrisburg; **PMS**; '74-'75 Academic Year
(1) Establishing Yourself in Medical Practice; at Host Inn; Mar. 4 and 5 (75-1-398)
(1) Principles of Medical Practice Management; at Penn Harris Motor Inn; May 2 and 3 (75-1-397)
MEDICAL ARTS '75; at Host Inn; Nov. 5-7 (75-1-399)
Contact: LeRoy C. Erickson, Dir. of Educ. Activities, Cncl. on Educ. and Science, PMS

Haverford State Hosp.; '74-'75 Academic Year
(1) The Psychiatrist and the Current Legal Scene; by **Institute;** weekly Jan. 14-Feb. 4 (75-1-307)
(1) Sharpening Your Skills in Marital Psychotherapy; by **Institute;** weekly Feb. 18-Mar. 25 (75-1-308)
Contact: Howard B. Rosen, M.D., Dir. of Prof. Educ., Haverford St. Hosp., 3500 Darby Rd., Haverford 19041

Hazleton St. Gen. Hosp.; '74-'75 Academic Year
(1) Continuing Medical Education; by **U. of Pa.;** St. Joseph Hosp., and Hazleton Branch Luzerne Co. Med. Soc.; Thursdays, Sept. 19-May 15 (75-1-47)
Contact: R. L. Gunderson, M.D., DME, Hazleton St. Gen. Hosp., Hazleton 18201

Hershey; **Dermatology;** Sept. 19-21, 1975
(1) Advances in Dermatology: 1975; by **Dermatology;** at Hotel Hershey (75-2-2)
Contact: Charles H. Greenbaum, M.D., Secy., Dermatology

Hershey; Heart Assn.; Apr. 3-4, 1975
(1) CPR Instructors' Training Course; by and at **M.S. Hershey** (75-1-378)
Contact: Dept. of Cont. Med. Educ., M.S. Hershey

Hershey; **M.S. Hershey;** '74-'75 Academic Year
(1) Evenings in Cardiology; 1st Wednesdays (75-1-24)
(1) Family & Community Medicine; Tuesdays (75-1-25)
(1) Anesthesiology Case Discussion; Tuesdays (75-1-355)
(1) Anesthesia Seminar; Wednesdays (75-1-356)
(1) Emergency Medicine Symposium; monthly, Wednesdays (75-1-26)
(1) Endocrinology and Reproductive Biology; Wednesdays (75-1-37)
(1) Medical Grand Rounds; Thursdays (75-1-27)
(1) Clinical Pharmacology Grand Rounds; semi-monthly, Mondays (75-1-357)
(1) Nervous System Seminar; monthly, Saturdays (75-1-358)
(1) Multidisciplinary Tumor Conference; Second and Fourth Fridays (75-1-359)
(1) OB/GYN Grand Rounds; Thursdays (75-1-29)
(1) Tri-county Pathology Assn.; Third Wednesdays (75-1-360)
(1) Tri-county Pathology Soc.; Fourth Wednesdays (75-1-361)
(1) Pediatrics Grand Rounds; Thursdays (75-1-31)
(1) Psychiatry Grand Rounds; 1st & 3rd Thursdays (75-1-34)
(1) Psychosomatic-Consultation Conference; Thursdays (75-1-362)
(1) Child Psychiatry Conference; Fridays (75-1-363)
(1) Radiology Grand Rounds; 1st & 3rd Thursdays (75-1-35)
(1) Surgical Grand Rounds; Thursdays (75-1-36)
(1) Orthopedic Surgery Grand Rounds; First Thursdays (75-1-364)
(1) Uroradiology Grand Rounds; Thursdays (75-1-365)
(1) Urology, Nephrology, Radiology Conference; First Wednesdays (75-1-366)
Contact: Ray A. Snyder, Area Director, Dept. of Cont. Med. Educ., M.S. Hershey

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Kingston; Nesbitt Hosp., '74-'75 Academic Year
(1) Continuing Education Program; by **Geisinger;** second Thursday each month Jan.-May (75-1-309)
Contact: Thomas Cadman, M.D., Geisinger

Kittanning; Armstrong Co. Mem. Hosp.; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; semi-monthly (75-1-138)
Contact: Roderick R. McLeod, M.D., Box 150, Kittanning 16201.

Lancaster Gen. Hosp.; '74-'75 Academic Year
(1) Program in Continuing Medical Education; by **Temple**, weekly (75-1-52)
(1) Clinical Correlation in Family Medicine; by **Temple**; weekly (75-1-199)
(1) Human Dimensions in Medicine; by **Temple** and **Institute**; weekly (75-1-200)
(1) Ambulatory Health Care Conference; by **Temple**; weekly (75-1-201)
(1) Medical Grand Rounds; by **Temple**; weekly (75-1-202)
(1) Monthly Staff Meeting; by **Temple** (75-1-203)
Contact: John H. Esbenshade, Jr., M.D., DME, Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17604

Lancaster Osteopathic Hosp.; '74-'75 Academic Year
(1) Counseling Sexual and Marital Problems; by **Institute;** Thursdays, Jan. 30-Feb. 27 (75-1-310)
Contact: Sydney E. Pulver, M.D., Dir., Phys. Educ. Project, Institute

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Lancaster; St. Joseph's Hosp.; '74-'75 Academic Year.
(1) Postgraduate Seminars for Physicians; by **Jefferson**; bi-monthly, Sept. 18 - May 28 (75-1-53)
Contact: Kenneth Carroll, M.D., Med. Dir., St. Joseph's Hosp., 250 College Ave., Lancaster 17604

Lansdale; **PAO & O;** Feb.-Dec. 1975
(1) Ophthalmic Reviews; by **PAO & O;** at Inter-County Ophthalmologic Soc. (75-2-3)
Contact: Paul Carmichael, M.D., 1000 N. Broad St., Lansdale 19446

Lebanon; Philhaven Hosp.; '74-'75 Academic Year
(1) Continuing Medical Education for Physicians; by Lebanon Co. Med. Soc. and **M.S. Hershey;** bi-monthly; Jan.-May (75-1-311)
Contact: Ray Snyder, Dir. of Cont. Med. Educ., M.S. Hershey

Lock Haven Hosp.; '74-'75 Academic Year

(1) Program of Continuing Medical Education; by **Polyclinic**; second and third Wednesdays Oct., Nov., Jan., Feb., Mar. (75-1-272)

Contact: William C. Long, Jr., M.D., 53 W. Main St., Lock Haven 17745

McKeesport Hosp.; '74-'75 Academic Year

(1) Continuing Education for Physicians; by **Pitt.**; weekly Winter of '75. (75-1-114)

Contact: Rudolph Buck, M.D., McKeesport Hosp., McKeesport 15132

Meadowbrook; Holy Redeemer Hosp.; '74-'75 Academic Year

(1) Medical Seminars for Physicians; by **Jefferson;** Sept. 18, 1974 - May 7, 1975 (75-1-19) Contact: W. F. Warrender, M.D., Co-Chrm. Educ. Cmte., Holy Redeemer Hosp., Meadowbrook 19046.

(1) Continuing Education Program; by **Hahnemann;** Oct. 10, 1974-Mar. 12, 1975 (75-1-11)

Contact: Robert J. Schaefer, Ex. Dir. Cont. Educ., Hahnemann

(1) The Physician's Role in the Addictions; by **Institute;** four sessions Jan. 9-Feb. 6 (75-1-312)

Contact: Sydney E. Pulver, M.D., Dir., Phys. Educ. Project, Institute

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Monongahela; Sept. 17, 1974 - Jan. 21, 1975

(1) Continuing Education for Physicians; by **Pitt**; alternately at Charleroi and Monongahela Div., Monongahela Valley Hosp. (75-1-42)

Contact: H. J. Levin, M.D., Monongahela Div., Monongahela Valley Hosp., Inc., 426 W. Main St., Monongahela 15063.

New Castle; Sept. 3, 1974 - Mar. 4, 1975

(1) Continuing Education for Physicians; by **Pitt** and Lawrence Co. Med. Soc. (75-1-109)

Contact: James Bower, M.D., Chrm. Cmte on Cont. Med. Educ., Lawrence Co. Med. Soc., Temple Bldg., New Castle 16101

New Castle; St. Francis Hosp., '74-'75 Academic Year

(1) Continuing Education for Physicians; by **Pitt;** monthly, Oct. 8-June 10 (75-1-354)

Contact: Frank J. Altomare, Jr., M.D., St. Francis Hosp., 1000 Mercer St., New Castle 16101

New Kensington; Jan. 8-Oct. 1, 1975

(1) Continuing Education for Physicians; by **Pitt** and Tri-County Branch Med. Soc.; at Holiday Inn; First Wed. each month (except June, July and Aug.) (75-2-24)

Contact: Walter N. Zuck, M.D., Citizens Gen. Hosp., New Kensington 15068.

New Stanton; '74-'75 Academic Year

(1) Continuing Education for Physicians; by **Pitt** and Westmoreland County Centralized Hosp. Service; at Inn America; Second Tues. each month, Sept.-June (75-1-400)

Contact: Mr. Ira S. Schugar, Dir., Educ. and Training, Westmoreland Co. Centralized Hosp. Service, P. O. Box 547, Greensburg 15601.

Oil City; '74-'75 Academic Year

(1) Continuing Education for Physicians; by **Pitt.**; alternately at Oil City, Titusville and Franklin Hosps. (75-1-113)

Contact: Robert M. Pilewski, M.D., Venango Co. Med. Soc., 9 Glenview Ave., Oil City 16301

Philadelphia; **ACP**; '74-'75 Academic Year

(1) Recent Developments in Medical Oncology; at Coll. of Phys. of Philadelphia; by **Jeanes**; May 12-14 (75-1-2)

Contact: Calvin F. Kay, M.D., Deputy Exec. Vice President, ACP

Philadelphia; Albert Einstein Med. Center - Northern Div.; '74-'75 Academic Year

(1) Anesthesia Seminar; by **Temple**; 3 days a week Oct 7 - May 29 (75-1-246)

(1) Cardio-Pulmonary-Renal Research Seminars; by **Temple**; every other week July 1 - June 20 (75-1-247)

(1) Network for Cont. Educ. TV Series; by **Temple**; 4 days a week, all year (75-1-248)

(1) TV Grand Rounds in Medicine; by **Temple**; weekly, Sept 18 - July 9 (75-1-249)

(1) Renal Conference; by **Temple**; weekly, all year (75-1-250)

(1) Kidney Transplant Conference; by **Temple**; weekly, all year (75-1-251)

(1) Medical Grand Rounds; by **Temple**; weekly, Sept 10 - June 24 (75-1-252)

(1) Basic Pathophysiology in Internal Medicine; by **Temple**; weekly, Sept. 9 - June 9 (75-1-253)

(1) Neurology Grand Rounds; by **Temple**; weekly, all year (75-1-267)

(1) Clinical Neurology and Neuro-ophthalmology; by **Temple**; weekly, Oct 3 - June 26 (75-1-254)

(1) Neuro-radiology Conference; by **Temple**; weekly, all year (75-1-255)

(1) Obstetrics and Gynecology Grand Rounds; by **Temple**; weekly, all year (75-1-256)

(1) Reproductive Endocrinology and Infertility; by **Temple**; every other week, Sept 3 - May 13 (75-1-257)

(1) Clinical Neuropathological Correlation Conference; by **Temple**; every other week all year (75-1-258)

(1) Autopsy Review Conference; by **Temple**; weekly, all year (75-1-259)

(1) Pediatric Grand Rounds; by **Temple**; weekly, all year (75-1-260)

(1) Nuclear Medicine - Introductory Physics and Clinical Aspects; by **Temple**; weekly, Apr. 2 - July 16 (75-1-261)

(1) Radiation Therapy - Introductory Physics and Clinical Aspects; by **Temple**; 2 days a week, Dec. 2 - Mar. 31 (75-1-262)

(1) Radiology Grand Rounds; by **Temple;** weekly, Sept. 16 - May 12 (75-1-263)

(1) Surgical Basic Science Conference and Lecture Series; by **Temple**; weekly, Sept. 3 - May 27 (75-1-264)

(1) General Surgery Conference; by **Temple**; weekly, Sept. 7 - June 28 (75-1-265)

(1) Departmental Surgical Conference; by **Temple**; weekly, Sept. 5 - June 26 (75-1-266)

Contact: Irving Woldow, M.D., Coordinator of Med. Educ., Albert Einstein Med. Center - Northern Div., York & Tabor Rds. Philadelphia 19141

Philadelphia; **Amer. Coll. of Cardiology;** '74-'75 Academic Year

(1) Echocardiography in Its Clinical Setting; Apr. 16-18, 1975 (75-1-290)

(1) Optimal Standards of Care in Cardiac Emergencies; Apr. 22-24, 1975 (75-1-291)

Contact: Miss Mary Anne McInerny, Dir., Dept. of Cont. Educ. Prgms., Amer. Coll. of Cardiology, 9650 Rockville Pike, Bethesda, Md. 20014

Philadelphia; **Colon and Rectal Surgery;** Jan. 24, 1975

(1) Continuing Education; at Union League; by **Colon and Rectal** (75-1-314)

Contact: Indru T. Khubchandani, M.D., Secy., Colon and Rectal

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Philadelphia; Emergency Physicians; Apr. 24-26, 1975

Fourth Annual Scientific Assembly of Pa. Chapter, Amer. Coll. of Emergency Phys. and EDNA; at Hilton of Philadelphia (75-1-313)

Contact: Joseph A. Fortuna, M.D., Philadelphia Health Management Corporation, 530 Walnut St., Philadelphia 19106

Philadelphia; Episcopal Hosp.; '74-'75 Academic Year

(1) Diagnostic Ultrasound Training Course-Introductory; Sept. 9-13 (repeated Dec. 9-13, Mar. 3-7, June 2-6); by **Temple** (75-1-143)

(1) Advanced Diagnostic Ultrasound Training Course in Abdominal Scanning; Oct. 21-25 (repeated Jan. 13-18, Apr. 7-11); by **Temple** (75-1-144)

(1) Advanced Diagnostic Ultrasound Training Course in Echocardiography; Nov. 11-15 (repeated Feb. 10-14, May 5-9); by **Temple** (75-1-145)

Contact: Albert J. Finestone, M.D., Assistant Dean for Cont. Med. Educ., Temple.

(1) Electrocardiography for the Practicing Physician; by **Temple;** weekly Nov.-Jan. (75-1-316)

Contact: Charles F. Sackett, M.D., Sect. of Cardiology, Episcopal Hosp., Front St. and Lehigh Ave., Philadelphia 19125.

(2) Phonocardiography/Vectorcardiography for the Practicing Physician; by **Temple;** weekly Feb.-Mar. (75-1-317)

Contact: Hass Shafia, M.D., Sect. of Cardiology

(2) Metabolic/Endocrine Problems for the Practicing Physician; by **Temple;** semi-monthly June-July (75-1-319)

Contact: Mansour Saberi, M.D., Sect. of Metabolism and Endocrinology

(2) Gastroenterologic Problems for the Practicing Physician; by **Temple;** semi-monthly July-June (75-1-320)

Contact: Prakash H. Joshi, M.D., Sect. of Gastroenterology

(2) Hematology for the Practicing Physician; weekly Sept.-June (75-1-318)

Contact: Sharon P. Fischer, M.D., Sect. of Hematology.

(1) Medical Grand Rounds; by **Temple;** weekly Oct.-May (75-1-315)

Contact: Jacob Zatuchni, M.D., Dept. of Med.

Episcopal Hosp., Front St. and Lehigh Ave., Philadelphia 19125

Philadelphia; **EPPI**; '74-'75 Academic Year

(1) Recent Advances in Child Psychiatry, Apr. 3 - May 8 (75-1-82)

(1) Introduction to Family Therapy: Practical Experience and Theoretical Applications; Wednesdays, Sept. 18 - Apr. 30 (75-1-83)

(1) Drug Interaction: Psychoactive Drugs in Combination with Other Commonly Prescribed Drugs; Thursdays, Jan. 1 - Feb. 20 (75-1-84)

(1) Altered States of Awareness in Psychotherapy; Feb. - Apr. (75-1-85)

Contact: Geraldine DePaula, M.D., Acting Dir. of CME, EPPI.

Philadelphia; **Frankford Hosp.;** '74-'75 Academic Year

(1) Continuing Education for Physicians; weekly, Sept. 13 - June 21 (75-1-244)

Contact: Ronald E. Cohn, M.D., Med. Dir., Frankford Hosp., 4940 Frankford Ave., Philadelphia 19124.

Philadelphia; **Hahnemann** '74-'75 Academic Year

(1) Rheumatology Tutorial; 8 days repeated Sept 2 - June 26 (75-1-236)

(1) Cardiac Radiology and Angiography Tutorial Course; 15 days, repeated Oct. 7 - June 27 (75-1-221)

(1) Hypertension, Clinical and Laboratory Tutorial; 10 days, repeated Sept. 2 - June 13 (75-1-226)

(1) Cardiac Care Unit Tutorial Course; 15 days, repeated Oct. 7 - June 27 (75-1-218)

(1) Cardio-Hemodynamics Tutorial Course; 15 days, repeated Oct. 7 - June 27 (75-1-219)

(1) Clinical Cardiology-Physiology and Pathophysiology; 15 days repeated Oct. 7 - June 27 (75-1-220)

(1) Clinical Cardiology and Cardiovascular Surgery Tutorial; 15 days, repeated Oct. 7 - June 27 (75-1-222)

(1) Noninvasive Cardiac Techniques Tutorial; 15 days, repeated Oct. 7 - June 27 (75-1-223)

(1) Vector Electrocardiography and Cardiovascular Pharmacology Tutorial; 15 days; repeated Oct. 7 - June 27 (75-1-224)

(1) Dialysis Tutorial Course; 10 days, repeated Sept. 2 - June 13 (75-1-225)

(1) Fluid and Electrolyte Metabolism Tutorial Course; 10 days; repeated Sept. 2 - June 13 (75-1-227)

(1) Fluid, Electrolyte and Acid Base Disorders; at Benjamin Franklin Hotel, Mar. 17-20 (75-1-22)

(1) Gastrointestinal Endoscopy Tutorial; 5 days, repeated Sept. 9 - June 13 (75-1-237)

(1) Clinical Gastroenterology Tutorial; 6 days, Sept 19-24 and Mar. 20 - Apr. 24 (75-1-238)

(1) General Medicine Reviews; May 5-9; at Marriott Motor Hotel (75-1-23)

(1) Chairman's Medical Grand Rounds; Thursdays, Oct. 3 - May 29 (75-1-239)

(1) Sex and the Life Cycle; at Benjamin Franklin Hotel; Mar. 17-20 (75-1-394)

(1) Bedside Diagnosis of Heart Disease; at Marriott Motor Hotel; July 14-16 (75-1-395)

(1) Review Seminar for Foreign Medical Graduates; June 16-July 31 (75-1-396)

(1) Internal Medicine Reviews; Wednesdays, Oct. 2 - Apr. 30 (75-1-240)

(1) Basic Tutorial Course; 60 days, repeated Sept. 9 - June 27 (75-1-241)

(1) Clinical Immunology Tutorial Course; 40 days, repeated Sept. 2 - June 27 (75-1-228)

(1) Clinical Pulmonary Disease Tutorial; 20 days, repeated Sept. 2 - June 27 (75-1-232)

(1) Pulmonary Physiology Tutorial; 20 days, repeated Sept. 2 - June 27 (75-1-233)

(1) Respiratory Intensive Care Tutorial; 20 days; repeated Sept. 2 - June 27 (75-1-234)

(1) Respiratory Inhalation Therapy Tutorial; 20 days, repeated Sept. 2 - June 27 (75-1-235)

(1) Respiratory Intensive Care Workshop; Oct. 14-25 and Apr. 14-25 (75-1-21)

(1) Adult Neurology Tutorial; 60 days, repeated Oct. 7 - June 27 (75-1-229)

(1) Pediatric Neurology Tutorial; 60 days, repeated Oct. 7 - June 27 (75-1-230)

(1) Neuropathology Tutorial; 60 days, repeated Oct. 7 - June 27 (75-1-231)

(1) Orthopedics for the Practicing Physician; Wednesdays, Apr. 2-30 (75-1-20)

Contact: Robert J. Schaefer, Exec. Dir., Cont. Educ., Hahnemann

(1) Psychological Pediatrics Conference; weekly. Sept 19 - May 8 (75-1-212)

(1) Basic Review of Neurology; weekly, Nov. - Jan. and Feb. - Apr. (75-1-213)

(1) Basic Review of Psychiatry; weekly, Nov. - Jan. and Feb. - Apr. (75-1-214)

(1) Human Sexuality; weekly, Mar. 26 - May 28 (75-1-215)

(1) Adolescence and the Youth Culture; weekly, Mar. 19 - May 21 (75-1-216)

Contact: Richard Hicks, M.D., Dept. of Mental Health Sciences, Hahnemann

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Philadelphia; Heart Assn.; Jan. 30-31, 1975 (repeat Apr. 17-18, 1975)

(1) CPR Instructors' Training Courses, by **PAFP;** At Emergency Care Research Inst. (75-1-377)

Contact: Emergency Care Research Inst., 913 Walnut St., Philadelphia 19107

Philadelphia; **Institute;** '74-'75 Academic Year

(1) Advances in Psychiatry & the Behavioral Sciences, 1st Thursdays, Sept.-June (75-1-78)

(1) Advances in Psychiatry & the Behavioral Sciences, Alternate Fridays, Jan.-May at Philadelphia St. Hosp. (75-1-79)

(1) Films and Human Personality; 1st Saturdays Oct.-Mar. (75-1-80)

(1) Literature and Human Personality; Last Tuesdays Sept.-Mar. (75-1-81)

(1) Public Speaking Workshop; Apr. 11-12 (75-1-323)

(1) Medical Writing Workshop; Mar. 7-8 (75-1-324)

(1) Review of Basic Neurology; Thursdays, Jan. 9-Mar. 13 (75-1-322)

Contact: Peter B. Bloom, M.D., Dir., Cont. Educ. in Psychiatry, Institute

(1) Medical Hypnosis; Wednesdays, Oct. 2-Mar. 5 (75-1-292)

(1) Counseling Sexual Problems (Advanced); 10 sessions, Mar. 6-May 29 (75-1-321)

Contact: Sydney E. Pulver, M.D., Dir., Phys. Educ. Project, Institute

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Philadelphia; **Jeanes;** '74-'75 Academic Year

(1) Anemia - Differential Diagnosis; Wednesdays, Apr. 2 - May 7 (75-1-89)

(1) Diagnosis and Treatment of Arrhythmia; Wednesdays, Feb. 19 - Mar. 26 (75-1-88)

(1) Cancer Detection in Office Practice; 5 consecutive Wednesdays, repeated Sept. - Apr; at Amer. Oncologic Hosp. (75-1-86)

(1) New Diagnostic Modalities in Radiology; Wednesdays, May 14 - June 18 (75-1-90)

(1) What Is This Skin Disease and How Do I Treat It?; Wednesdays, Jan. 8 - Feb. 12 (75-1-87)

Contact: Joseph M. Winston, M.D., D.M.E., Jeanes Hosp., Philadelphia 19111

Philadelphia; **Jefferson;** '74-'75 Academic Year

(1) Pain and Discomfort; Tuesdays, Jan. 14-Apr. 22 (75-1-325)

Contact: John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson

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Philadelphia; John F. Kennedy Mem. Hosp; '74-'75 Academic Year

(1) Continuing Education Program; by **Hahnemann** (75-1-77)

Contact: Robert J. Schaefer, Exec. Dir., Cont. Educ., Hahnemann

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Philadelphia; **MCP;** '74-'75 Academic Year

(1) Preceptorships for Practicing Physicians (in sub specialties); scheduled as convenient (75-1-211)

Contact: Gerald H. Escovitz, M.D., Assoc. Dean, MCP

Philadelphia; Lung Assoc.; Mar. 18-19, 1975

(1) TB '75 Symposia; by **U. of Pa.;** at Holiday Inn-Independence Mall (75-1-403)

Contact: Robert J. Reza, M.D., Med. Officer, Div. of Chronic Respiratory Disease, Pa. Dept. of Health, P. O. Box 90, Harrisburg 17120

Philadelphia; Memorial Hosp., Roxborough; '74-'75 Academic Year

(1) Orthopedics Seminar; by **PAFP;** Mar. 20 (75-1-326)

(1) Tuesday Afternoon Lecture Series; by **PAFP;** Sept. 10-June 24 (75-1-349)

Contact: Janet A. Hampton, M.D., Acting Dir., Comm. on Staff Educ., Memorial Hosp., 5800 Ridge Ave., Philadelphia 19128

Philadelphia, Philadelphia Gen. Hosp.; '74-'75 Academic Year

(1) Dermatology Staff Conference; Thursdays; by **U. of Pa.** (75-1-278)

(1) Neuroradiology Clinical Correlation Conference; Wednesdays; by **U. of Pa.** (75-1-279)

(1) PM&R Teaching Conference and Journal Club; Thursdays; by **U. of Pa.** (75-1-280)

(1) PM&R & Psychiatric Conference; Mondays; by **U. of Pa.** (75-1-281)

(1) Prosthetic - Orthotic Conference; fourth Thursdays; by **U. of Pa.** (75-1-282)

(1) Psychiatry Departmental Academic Seminar; Tuesdays; by **U. of Pa.** (75-1-283)

(1) Surgical Pathology Conference; first Tuesdays; by **U. of Pa.** (75-1-284)

(1) Mortality/Morbidity Conference; fourth Tuesdays; by **U. of Pa.** (75-1-285)

(1) Tumor Conference; Tuesdays; by **U. of Pa.** (75-1-286)

(1) Weekly Psychiatric Case Conference; Wednesdays; by **U. of Pa.** (75-1-287)

Contact: Henry G. Sparks, Coordinator, Cont. Educ. Program, U. of Pa.

Philadelphia; St. Christopher's Hosp.

(1) 24th Annual Pediatric Seminar; by **Temple;** May 6-9, 1975; at Benjamin Franklin Hotel, Philadelphia (75-1-18)

Contact: Angelo M. DiGeorge, M.D., St. Christopher's Hosp. for Children, 2600 N. Lawrence St., Philadelphia 19133

Philadelphia; **Temple;** '74-'75 Academic Year

(1) Anesthesiology Seminar; Thursdays (75-1-190)

(1) Anesthesiology Basic Science Lecture; Wednesdays (75-1-191)

(1) Anesthesiology Case Conference, Thursdays (75-1-192)

(1) Thrombohemorrhagic Conference; Fridays (75-1-165)

(1) Cardiac Arrhythmia Conference; Thursdays (75-1-160)

(1) Cardiac Catheterization Conference; Fridays (75-1-164)

(1) Chest Conference; Wednesdays (75-1-158)

(1) Rheumatology Conference; Thursdays (75-1-159)

(1) Infectious Disease Clinical Microbiology Conference; Thursdays (75-1-161)

(1) Pulmonary Grand Rounds; Fridays (75-1-162)

(1) G. I. Conference; Fridays (75-1-163)

(1) Clinical Dermatology Conference; Thursdays; at Skin and Cancer Hosp. (75-1-174)

(1) Office Dermatology; May 14 (75-1-16)

(1) Office Endocrinology; May 21 (75-1-13)

(1) Preceptor Program in Emergency Room Medicine; Apr. 28 - May 16 (75-1-146)

(1) Socratic Seminars; subject - place - format chosen by applicant (75-1-151)

(1) Hepatology Conference; Mondays (75-1-154)
(1) Endocrine-Metabolic Conference; Tuesdays (75-1-155)
(1) CPC/Medicine; Wednesdays (75-1-156)
(1) Medical Grand Rounds; Wednesdays (75-1-157)
(1) Musculoskeletal Problems As Seen in Office Practice; Apr. 16 (75-1-15)
(1) New Developments in Pulmonary Embolism and Venous Thrombosis; Mar. 12 (75-1-153)
(1) Management of Benign Intractable Pain; May 7 (75-1-14)
(1) Human Sexuality and Related Problems; Mar. 28-29 (75-1-12)
(1) Neuroradiology Conference; Tuesdays (75-1-182)
(1) Grand Rounds in Neurosurgery; Fridays (75-1-183)
(1) Neurology Conference; Tuesdays (75-1-181)
(1) Ob Gyn Grand Rounds; Mondays (75-1-169)
(1) Ob Gyn Postgraduate Program; Wednesdays (75-1-170)
(1) Hemiplegic Rehabilitation; Apr. 17-18 (75-1-148)
(1) Concepts and Implications of Sensory Feedback Therapy; May 15-16 (75-1-149)
(1) Frontiers of Psychotherapy; Mar. 13-14; at Albert Einstein Med. Center (75-1-147)
(1) Rehabilitation Chairman's Rounds; Tuesdays (75-1-178)
(1) Electrodiagnostic Rounds; Thursdays (75-1-179)
(1) Orthotic Rounds; Tuesdays (75-1-180)
(1) Grand Rounds in Psychiatry; First Fridays (75-1-177)
(1) Neuroradiology; Tuesdays (75-1-184)
(1) Hematology-Oncology Conference; Mondays (75-1-245)
(1) Tumor Conference; Thursdays (75-1-175)
(1) Basic Science Seminar; Wednesdays; at Fels Research Inst. (75-1-176)
(1) Orthopedic Surgery Grand Rounds, Wednesdays (75-1-193)
(1) Fracture Conference; Tuesdays (75-1-194)
(1) Anatomy Conference and Class; Thursdays (75-1-195)
(1) Orthopedic Radiology; Saturdays (75-1-196)
(1) Orthopedic Surgery Basic Science Conference; Saturdays (75-1-197)
(1) Patient Care Mortality and Morbidity Conference (Orthopedic Surgery); Saturdays (75-1-198)
(1) Microsurgery Ophthalmologic Workshops; Spring 1975; at Sugar Loaf Conference Center (75-1-150)
(1) Chevalier Jackson Course in Bronchoesophagology; Oct. 28 - Nov. 8 (repeat) Feb. 3-14 (75-1-46)
(1) Pediatric Grand Rounds; Tuesdays and Fridays; at St. Christopher's Hosp. for Children (75-1-171)
(1) Pediatric Conference; Thursdays; at St. Christopher's Hosp. for Children (75-1-172)
(1) Pediatric Ophthalmology Symposium; May 8-9; at Coll. of Phy. of Philadelphia (75-1-17)
(1) Pediatric Cardiology Conference; Fridays; at St. Christopher's Hosp. for Children (75-1-173)
(1) Pediatric Radiology; Wednesdays (75-1-185)
(1) Urologic Radiology; alternate Thursdays (75-1-186)
(1) Angiography; Fridays (75-1-187)
(1) Stauffer Lecture (Radiology); Apr. 23 (75-1-188)
(1) Sports Medicine Clinics; weekly, Apr. (75-1-152)
(1) Basic Science (Surgery) Review; Tuesdays (75-1-166)
(1) Clinical Pathology Radiology Conference; Wednesdays (75-1-167)
(1) Surgical Morbidity Conference; Saturdays (75-1-168)
(1) Urologic Radiology Conference; Mondays (75-1-189)
Contact: Albert J. Finestone, M.D., Assistant Dean for C.M.E., Temple.

Philadelphia; **U. of Pa.** Hosp.; '74-'75 Academic Year.
(1) Anesthesia Case Conference; Thursdays (75-1-273)
(1) Angiography Conference; second Wednesdays (75-1-274)
(1) Cardiology Conference; Thursdays (75-1-275)
(1) Neuroradiology Conference; Saturdays (75-1-276)
(1) Surgical Grand Rounds; Saturdays (75-1-277)
(1) Suburban Pathology Society; first Wednesdays at Montgomery Co. Med. Soc. (75-1-289)
(1) Pathology Society of Philadelphia; second Thursdays; at Coll. of Phys. (75-1-288)
Contact: Henry G. Sparks, Coordinator, Cont. Educ. Program, U. of Pa.

Philadelphia; Wills Eye Hosp., '74-'75 Academic Year
(1) Third Annual Course on Oculo-Plastic Surgery; by **PAO&O**; Apr. 24-26 (75-1-8)
Contact: Gerard Shannon, M.D., Dir. Oculo-Plastic Serv., Wills Eye Hosp., 16th & Spring Garden Sts., Philadelphia 19130
(1) Diagnosis and Management of Glaucoma; by **PAO&O**, Apr. 10-12 (75-1-7)
Contact: George Spaeth, M.D., Dir., Glaucoma Serv., Wills Eye Hosp.; 16th and Spring Garden Sts., Philadelphia 19130

Pittsburgh; **Allegheny;** '74-'75 Academic Year
(1) Anesthesia Conference; each Tuesday (75-1-337)
(1) Gastroenterology Conference; each Thursday (75-1-333)
(1) Medical Grand Rounds; each Wednesday (75-1-336)
(1) Neurosciences Conference; each Friday (75-1-344)
(1) Obstetrics/Gynecology Conference; each Monday (75-1-343)
(1) Obstetrics/Gynecology Conference; each Thursday (75-1-334)
(1) Oncology Conference; monthly, First Thursday (75-1-332)
(1) Pathology-Oncology Slide Seminar; each Friday (75-1-331)
(1) Clinical Pathological Conference; monthly, last Friday (75-1-328)
(1) Laboratory Medicine Seminar; monthly, second Friday (75-1-329)
(1) Medical Mortality Conference; First and Third Fridays (75-1-330)
(1) Pediatric Visiting Professor Rounds; each Tuesday (75-1-341)
(1) Pediatric Conference; bi-monthly, Mondays (75-1-342)
(1) Surgery-Radiology-Pathology Conference; each Tuesday (75-1-338)
(1) Surgical Grand Rounds; each Thursday (75-1-335)
(1) Cardio-Thoracic Conference; each Tuesday (75-1-339)
(1) Thoracic Surgery Conference; each Tuesday (75-1-340)
Contact: Thomas W. Sheridan, Educ. Coordinator, Allegheny

Pittsburgh; Heart Assn.; May 9-11, 1975
(1) CPR Instructors' Training Course; by and at **Pitt** (75-1-379)
Contact: Div. of Cont. Educ., Pitt

Pittsburgh; Lung Assoc.; Apr. 22-23, 1975
(1) TB '75 Symposia; by **Pitt;** at Chatham Center (75-1-403)
Contact: Robert J. Reza, M.D., Med. Officer, Div. of Chronic Respiratory Disease, Pa. Dept. of Health, P. O. Box 90, Harrisburg 17120.

Pittsburgh; **Mercy**; '75-'76 Academic Year
(1) Anesthesiology Basic Science Lectures; Wednesdays (75-1-75)
(1) Cardiology Seminars; Wednesdays (75-1-74)
(1) Seminars in Medicine; Saturdays (75-1-73)
(1) Mercy Day Scientific Conference; Sept. 1975 (75-2-4)
(1) Otolaryngology and Maxillofacial Conference; Saturdays (75-1-76)
(1) Concepts in Soft Tissue Surgery; Jan. 27-31, 1975. (75-1-3)
Contact: John J. Kenny, M.D., Chrm., Cont. Med. Educ., Mercy Hosp., 1400 Locust St., Pittsburgh 15219.

Pittsburgh; North Hills Passavant Hosp.; Sept. 25, 1974 - May 22, 1975
(1) Continuing Education for Physicians; by **Pitt.**; monthly (75-1-115)
Contact: Herbert Anderson, M.D., North Hills Passavant Hosp., 9100 Babcock Blvd., Pittsburgh, 15237

Pittsburgh; **Pitt.;** '74-'75 Academic Year
(1) Seminars in Clinical Cardiology; Wednesdays (75-1-130)
(1) Seminars for the Practicing Physician; weekly, Wednesdays and Thursdays (75-1-129)
(1) Fourth Annual Symposium on Sports Medicine; at Chatham Cntr.; Mar. 21, 1975 (75-1-382)
(5) Lunch Box Theatre; Wednesdays (75-1-128)
(1) The Law and the Physician; Wednesdays, Jan. 8-Mar. 26 (75-1-132)
(1) Biochemical Mechanisms of Disease; Tuesdays, Jan. 14-Apr. 8 (75-1-133)
(1) Critical Care Medicine (9th Annual Symposium); May 7-10, 1975 (75-1-388)
(1) Diseases Due to Immune Mechanisms; at Wm. Penn Hotel; Sept. 25-28, 1975 (75-2-22)
(1) Nuclear Medicine Review; May 1-2, 1975 (75-1-386)
(1) Symposium on Head and Neck Cancer; May 21, 1975 (75-1-380)
(1) Strabismus; at Eye and Ear Hosp., Apr. (75-1-384)
(1) Ophthalmic Micro-surgery; at Eye and Ear Hosp., Apr. 30-May 2—Section 1 or May 5-7—Section 2 (75-1-385)
(1) Management of Retinal Detachment; at Eye and Ear Hosp.; Aug. 4-8, 1975 (75-1-390)
(1) Anatomy and Surgery of the Nose; Feb. 9-15; at Eye and Ear Hosp. (75-1-134)
(1) Pediatric Otolaryngology; May 9-10, 1975 (75-1-387)
(1) Electronic Imaging Techniques in Diagnostic Radiology; at Seven Springs Mt. Resort; Oct. 16-18, 1975 (75-2-23)
(1) Applied Surgical Anatomy; Jan. 6-Mar. 14, 1975 (75-1-131)
(1) Fifth Annual Seminar and Workshop in Diagnostic and Operative Laparoscopy; Jan. 9-10, 1975 and Apr. 3-4, 1975; at Magee-Women's Hosp. (75-1-381)
(1) Use of Staplers in Surgery (4th Workshop); Feb. 24-25, 1975 (75-1-383)
(1) Contemporary Problems in Surgery; June 12-14, 1975 (75-1-389)
Contact: William M. Cooper, M.D., Dir., Div. of Cont. Educ., Pitt.

Pittsburgh; Pittsburgh Otological Soc.; '74-'75 Academic Year
(1) Otolaryngology Conferences; Four Single Days; by **PAO&O** (75-1-55)
Contact: Herman Felder, M.D., Secy., Pittsburgh Otological Soc., 3600 Forbes Ave., Pittsburgh 15213

Pittsburgh; Shadyside Hosp.; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; monthly (75-1-117)
Contact: William J. Garner, M.D., Shadyside Hosp., Centre Ave., Pittsburgh 15232

Pittsburgh; St. Clair Mem. Hosp.; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; monthly (75-1-116)
Contact: W. Lawrence Wilson, M.D., Chrm., Med. Educ. Cmte., St. Clair Mem. Hosp., 1000 Bower Hill Rd., Pittsburgh 15243

Pittsburgh; **St. Francis**; '74-'75 Academic Year
(1) Medical Grand Rounds; Wednesdays, Aug. 1 - June 15 (75-1-139)
(1) Ob/Gyn Conference; First and Third Wednesdays, Sept. 9 - June 30 (75-1-140)
(1) PM & R Grand Rounds; Wednesdays, Sept. 3 - June 30 (75-1-141)
(1) Grand Surgical Ward Rounds; Fridays, Sept. 3 - June 30 (75-1-42)
Contact: Joseph A. Marasco, Jr., M.D., Dir. of Cont. Educ., St. Francis Gen., Pittsburgh 15201

Pittsburgh; St. John's Gen. Hosp.; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; monthly; alternately at St. John's Gen. and Suburban Gen. Hosps. (75-1-37)
Contact: R. J. Wojciak, D.O. St. John's Gen. Hosp., 3339 McClure Ave., Pittsburgh 15212.

Pittsburgh; **St. Margaret**; '74-'75 Academic Year
(1) Arthritis and the Rehabilitation Team (75-1-56)
(1) Cardiology Conferences; Alternate Fridays (75-1-57)
(1) Community and Family Practice Seminars (75-1-58)
(1) Continuing Medical Education and Postgraduate Lectures (75-1-59)
(1) Neurology Conferences; 2nd and 4th Fridays (75-1-60)
(1) OB-GYN Conference; Alternate Tuesdays (75-1-61)
(1) Pediatric Conference; Alternate Tuesdays (75-1-62)
(1) Psychiatry Seminars in Family Practice (75-1-63)
(1) Radiology Conferences (75-1-64)
(1) Rehabilitation Team in Action (75-1-65)
(1) Rheumatology Grand Rounds; Monthly (75-1-66)
(1) Rheumatology for the Orthopedic Surgeon (75-1-67)
(1) Rheumatology-Pathology Review (75-1-68)
(1) Rheumatology-Radiology Review (75-1-69)
(1) Selected Topics in Rheumatology (75-1-70)
(1) Surgery Conference (75-1-71)
(1) Workshop in Rheumatology and Orthopedics (Surgical Indications); 6 days a mo. (75-1-72)
Contact: Paul W. Dishart, M.D., Coordinating Director, CME, St. Margaret

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Pittsburgh; Staunton Clinic; '74-'75 Academic Year
(1) Seminars in Patient Care for Physicians; by **Pitt;** Wednesdays, 13 weeks starting Jan. 8, 1975 (75-1-392)
(1) Case Centered Seminars in Psychotherapy for Psychiatrists; by **Pitt;** 10 sessions (75-1-391)
Contact: Rex A. Pittenger, M.D., Dir., Staunton Clinic, 3601 Fifth Ave., Pittsburgh 15261

Pittsburgh; Suburban Gen. Hosp.; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; monthly; alternately at Suburban Gen. Hosp. and St. John's Gen. Hosp. (75-1-137)
Contact: Wayne Greenburg, M.D., Suburban Gen Hosp., S. Jackson Ave., Pittsburgh 15202

Pittsburgh; **West Penn** '74-'75 Academic Year
(1) Cardiology Workshop-1975; Feb. 23 (75-1-345)
(1) Cardiology Workshop-1975; Mar. 2 (75-1-345)
(1) Dermatology Conference; Second and Fourth Tuesdays (75-2-17)
(1) Gastroenterology Conference; First Mondays (75-2-5)
(1) Hematology Conference; Second and Fourth Wednesdays (75-2-16)
(1) Medical Grand Rounds; First, Second, Third and Fifth Thursdays (75-2-15)
(1) Medical Mortality Conference; Fourth Thursdays (75-2-14)
(1) Metabolic/Endocrine/Renal Conference; Second and Fourth Mondays (75-2-6)
(1) Psychiatry Symposium; Second and Fourth Fridays (75-2-13)
(1) Pulmonary Conference; First, Third and Fifth Tuesdays (75-2-18)
(1) Rheumatology Conference; Third Monday (75-2-19)
(1) OB/GYN Grand Rounds; every Friday (75-2-7)
(1) Pediatric Visiting Professor Rounds; every Tuesday (75-2-8)
(1) Surgical Mortality Conference; Fourth Fridays (75-2-9)
(1) Surgical Grand Rounds; Second, Third and Fifth Fridays (75-2-10)
(1) Chest and Vascular Conference; Second and Fourth Thursdays (75-2-11)
(1) Surgery/Radiology/Pathology Conference; Second and Fourth Tuesdays (75-2-12)
Contact: James B. Hanrahan, M.D., Vice Chairman, Postgraduate Educ. Cmte., West Penn

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Pottsville; Good Samaritan Hosp.; '74-'75 Academic Year
(1) Continuing Education Program; by **U. of Pa.**; monthly, Sept. 19 - May 29 (75-1-293)
Contact: Office of Cont. Educ., U. of Pa.

Pottsville; Pottsville Hosp. & Warne Clinic; '74-'75 Academic Year
(1) Postgraduate Seminars for Physicians; by **Jefferson;** first Thursdays Sept 5 - June 5 (75-1-1)
Contact: E. W. Cubler, M.D., D.M.E., Pottsville Hosp. and Warne Clinic, 420 S. Jackson St., Pottsville 17901.

Reading Eye, Ear, Nose and Throat Soc.; '74-'75 Academic Year
(1) Combined EENT Conferences; by **PAO&O** monthly, Sept. - Apr. (75-1-54)
Contact: Donald Burns, M.D., Secy., Reading Eye, Ear, Nose and Throat Soc., 1500 Penn Ave. Wyomissing 19610

Reading; St. Joseph's Hosp.; '74-'75 Academic Year
(1) Continuing Medical Education for Physicians; by **M.S. Hershey;** Fourth Wednesday, Sept.-June (75-1-346)
Contact: Ray Snyder, Dir. C.M.E., M.S. Hershey

Roaring Spring; Nason Hosp.; Sept 3, 1974 - June 5, 1975
(1) Continuing Education for Physicians; by **Pitt.**; First Tuesdays (75-1-118)
Contact: Marion A. Morelli, M.D., Chrm. Educ. Cmte., Nason Hosp., Roaring Spring 16673

Rochester; Sept 18, 1974 - May 21, 1975
(1) Continuing Education for Physicians; by **Pitt.**; alternately at Beaver Co. and Aliquippa Hosps., Third Wednesdays (75-1-119)
Contact: Mrs. Susan Frey, Exec. Secy., Beaver Co. Med. Soc., 350 Adams St., Rochester 15074.

Sayre; **Packer** '74-'75 Academic Year
(1) The Cardiac Patient: Anesthetic and Surgical Considerations; Jan. 25 (75-1-347)
(1) Surgical Grand Rounds; Saturdays (75-1-268)
(1) Tumor Conference; second and fourth Thursdays (75-1-269)
(1) Clinical Pathological Conference; third Wednesdays (75-1-270)
(1) Medical Grand Rounds; Fridays (75-1-271)
Contact: Paul C. Royce, M.D., Ph. D., D.M.E., Packer

Scranton; Community Med. Cntr.; Jan. 8, 1975
(1) Postgraduate Seminars for Physicians; Dec. and Jan.; by **Jefferson** (75-1-393)
Contact: Arthur C. F. Zobel, M.D., Community Med. Cntr., 1822 Mulberry St., Scranton 18501

Sharon Gen. Hosp.; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt**; monthly; at Tumor Clinic (75-1-135)
Contact: Thomas V. Murray, M.D., Dir., Tumor Clinic, Sharon Gen. Hosp., East State St., Sharon, 16147
(1) Continuing Education for Physicians; by **Pitt.**; first and third Wednesdays (75-1-120)
Contact: Allen H. Holt, M.D., Mercer Co. Med. Soc., 32 Jefferson Ave., Sharon 16146

Sunbury; Sept 11 - Nov. 27, 1974
(1) Continuing Education Program; by **Hahnemann** and Northumberland and Union County Medical Societies; at Community Hosp. (75-1-9)
Contact: Willard W. Christman, M.D., Dir. of Med. Educ., Community Hosp., Sunbury 17801

Sunbury Community Hosp.; Sept. 11-Apr. 23, 1975
(1) Continuing Education Program; by **Hahnemann** and Northumberland and Union Co. Med. Societies (75-1-9)
Contact: Willard W. Christman, M.D., Dir. of Med. Educ., Community Hosp., Sunbury 17801

Titusville; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; alternately at Titusville, Franklin and Oil City Hosps. (75-1-113)
Contact: Robert M. Pilewski, M.D., Venango Co. Med. Soc., 9 Glenview Ave., Oil City 16301

Uniontown Hosp.; Sept. 25, 1974 - May 28, 1975
(1) Continuing Education for Physicians; by **Pitt.**; Fourth Wednesdays (75-1-121)
Contact: Walter Lion, Exec. Secy., Fayette Co. Med. Soc., 30 Delaware Ave., Uniontown 15401

University Park; '74-'75 Academic Year
(1) Chairman's Medical Grand Rounds (video-cassettes); at Ritenour Health Center; by **Hahnemann**; weekly (75-1-243)
Contact: John A. Hargleroad, II, M.D., Ritenour Health Center, Pa. State Univ., University Park 16802

Washington Hosp.; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt**; monthly (75-1-122)
Contact: John Pirris, M.D., Chrm., Staff Educ. Cmte., Washington Hosp., 155 Wilson Ave., Washington 15301

Washington Hosp.; 1975 Year
(1) Continuing Medical Education Program; weekly (75-2-20)
Contact: John Pirris, M.D., Chrm., Staff Educ. Comm., Washington

Wellsboro; Oct. 16, 1974 - June 18, 1975
(1) Postgraduate Seminars for Physicians; at Soldiers and Sailors Mem. Hosp.; by **Jefferson** (75-1-4)
Contact: Mr. Ralph C. Antrim, Admin., Soldiers and Sailors Mem. Hosp., Wellsboro 16901

Wilkes-Barre; Luzerne Co. Med. Soc.; 1975 Year
(1) Postgraduate Seminars for Physicians; by **Jefferson;** second Wednesday, Feb.-Nov. (except July and Aug.) (75-2-21)
Contact: William Grossman, M.D., Chrm., Educ. Prgm., Luzerne Co. Med. Soc., 130 S. Franklin St., Wilkes-Barre 18701

Wilkes-Barre; Mercy Hosp.; '74-'75 Academic Year
(1) A Program of Continuing Medical Education; by **Gelsinger** (75-1-348)
Contact: John P. Brennan, M.D., Chrm., Educ. Cmte., Mercy Hosp., 196 Hanover St., Wilkes-Barre 18703

Wilkes-Barre; Wyoming Valley Hosp.; '74-'75 Academic Year
(1) Continuing Education Program; by **Hahnemann**; weekly, Sept. 11 - May 28 (75-1-48)
Contact: Robert J. Schaefer, Exec. Dir., Cont. Educ., Hahnemann

Williamsport; Williamsport Hosp.; '74-'75 Academic Year
(1) Continuing Education Program; by **U. of Pa.**; Second Fridays, Sept. - June (75-1-43)
Contact: Herman W. Rannels, M.D., Vice President and Med. Dir., Williamsport Hosp., 777 Rural Ave., Williamsport 17701

York Hosp.; Sept. 12, 1974 - Apr. 24, 1975
(1) Seminars in Continuing Medical Education; by **Jefferson**; weekly (75-1-44)
Contact: Merle S. Bacastow, M.D., Vice Pres. Med. Affairs, York.

CALENDAR

A quick reference to Category One continuing medical education opportunities in Pennsylvania by date.

JANUARY

3	Approach to Patient with Proteinuria; at St. Clair Mem. Hosp., Pittsburgh (75-1-116)
6-Feb 14 •	Applied Surgical Anatomy; at Pitt. (75-1-131)
7	Anaerobic Bacterial Infections; at Butler Holiday Inn (75-1-111)
7	Orthopedics; at Canonsburg Gen. Hosp. (75-1-112)
7	Peptic Ulcer Disease; at Philhaven Hosp., Lebanon (75-1-311)
7	Current Concepts in Oncology—Diagnosis and Management; at New Castle Country Club (75-1-109)
7	Medical, Social and Psychological Aspects of Abortion; at Memorial Hosp., Philadelphia (75-1-349)
7	Current Concepts in Hematology; at Nason Hosp., Roaring Spring (75-1-118)
8	Common ENT Problems; at Lock Haven Hospital (75-1-272)
8	Genetics—1975; at New Kensington (75-2-24)
8	Shock Lung Syndrome; at Community Med. Cntr., Scranton (75-1-393)
8	Gynecology Conference, Psy. Conf.; at Washington Hosp. (75-1-122)
8- 9	Coronary Angiography—Why and When; at Pitt (75-1-129)
9	Patient with known Penicillin Allergy and S.B.E. with Negative Blood Cultures; at Altoona Hosp. (75-1-39)
9	Heart Disease in Pregnancy; at Hazleton St. Gen. Hosp. (75-1-47)
9	PSRO Utilization; at Nesbitt Hosp., Kingston (75-1-309)
9	Bloody Stools; at Pottsville Hosp. (75-1-1)
9-10 •	Fifth Annual Seminar (Winter Series) and Workshop in Diagnostic and Operative Laparoscopy; by Pitt (75-1-381)
10	Edema and Hyponatremia; at Williamsport Hosp. (75-1-43)
13-16 •	Advanced Diagnostic Ultrasound Training Course in Abdominal Scanning; by Temple, Philadelphia (75-1-144)
14	The Unconscious Patient; at Mayview St. Hosp., Bridgeville (75-1-110)
14	Systemic Disorders Manifesting As Pain and Discomfort in Lower Extremity; at Jefferson, Philadelphia (75-1-325)
14	Legal Aspects of Abortion; at Memorial Hosp., Philadelphia (75-1-349)
14	Management and Evaluation of Patient with Chronic Obstructive Pulmonary Disease; New Stanton (75-1-400)
15	Tuberculosis; at Allentown Hosp. (75-1-38)
15	Pediatric Urologic Problems; at Hanover Gen. Hosp. (75-1-295)
15	Management of Acute Pediatric Cardiac Emergencies; at Lock Haven Hospital (75-1-272)
15	Rheumatology; at McKeesport Hosp. (75-1-114)
15	Thyroid Problems; at Shadyside Hosp., Pittsburgh (75-1-117)
15	Differential Dx of Strokes & Immediate Rx; at Suburban General Hosp., Pittsburgh (75-1-137)
15	Fetal Monitoring—Intensive Care of Newborn; at Beaver Co. Hosp., Rochester (75-1-119)
15	Cancer Immunology; at Sharon Gen. Hosp. (75-1-120)
15	Office Gynecology; at Soldiers & Sailors Mem. Hosp.; Wellsboro (75-1-4)
15-16	Indications for and Results of Coronary Artery Surgery; at Pitt (75-1-129)
16	Allergic Drug Reactions: The Penicillin Model; at Bryn Mawr Hosp. (75-1-350)
16	Ca of the Prostate; at Hazleton St. Gen. Hosp. (75-1-47)
17	Current Problems in Surgery of the Biliary Tract; at Bryn Mawr Hosp. (75-1-351)
18	Dermatology; at Armstrong Co. Mem. Hosp., Kittanning (75-1-138)
21	Newer Diagnostic Techniques—How to & When to Use; at Abington Mem. Hosp. (75-1-5)
21	Recent Advances in Diabetes; at Bryn Mawr Hosp. (75-1-352)
21	Diseases Due to Protein Abnormalities; Monongahela Div., Monongahela Valley Hosp. (75-1-42)
21	Differential Diagnosis of Acute Abdominal Pain; at St. Francis Hosp., New Castle (75-1-354)
21	Disorders of the Skeletal System Causing Lower Extremity Pain and Discomfort; at Jefferson, Philadelphia (75-1-325)
21	Cancer Chemotherapy; at Memorial Hosp., Philadelphia (75-1-349)
22	Reappraisal of the "Pill"; at St. Joseph Hosp., Lancaster (75-1-53)
22	Lymphomas; at McKeesport Hosp. (75-1-114)
22	Degenerative Arthritis of Hip and Knee; at St. Joseph's Hosp., Reading (75-1-346)
22	Common Causes of Peripheral Neuropathies—Diagnosis and Treatment; at Uniontown Hosp. (75-1-121)
22	Internal Medicine Day; at Washington Hosp. (75-1-122)
22-23	Laboratory: New Tests and Significance; at Pitt (75-1-129)
23	Flank Pain, Fever and Hematuria; at Altoona Hosp. (75-1-39)
23	Hyperlipidemias; at Hazleton St. Gen. Hosp. (75-1-47)
23	Headaches: Differential Dx and Treatment; at Holy Redeemer Hosp., Meadowbrook (75-1-11)
23	Chronic Renal Disease and Current Therapeutic Modalities; at North Hills Passavant Hosp., Pittsburgh (75-1-115)
24	Continuing Education in Colon and Rectal Surgery; at Colon and Rectal Surgery, Philadelphia (75-1-314)
25	The Cardiac Patient: Anesthetic and Surgical Considerations; at Packer, Sayre (75-1-347)
27-31 •	Concepts in Soft Tissue Surgery; at Pittsburgh Mercy (75-1-3)

KEY:
• Indicates session that will be presented at a specialty level.

(75-1-XX) Numbers in parentheses at the end of the item are code numbers which will be helpful as a reference to find a contact for more information.
See: town, institution and code numbered item in "Announcements" section for complete details.

28 Newer Diagnostic Techniques—How to & When to Use; at Abington Mem. Hosp. (75-1-5)
28 Diagnosis and Treatment of Foot Disorders; at Jefferson, Philadelphia (75-1-325)
28 C.P.C.; at Memorial Hosp., Philadelphia (75-1-349)
29 Acute Renal Disease or Renal Failure; at McKeesport Hosp. (75-1-114)
29-30 Hypertension: Screening Techniques—Secondary Causes; at Pitt (75-1-129)
30 Hyperuricemia; at Hazleton St. Gen. Hosp. (75-1-47)
30 Symposium on the Kidney; Good Samaritan Hosp., Pottsville (75-1-293)
30-31 CPR Instructors' Training Course; by Heart Assn., Philadelphia (75-1-377)

FEBRUARY

1 VD In Daily Practice; at Armstrong Co. Mem. Hosp., Kittanning (75-1-138)
3-14 Bronchoesophagology; at Temple, Philadelphia (75-1-46)
4 Newer Diagnostic Techniques—How to & When to Use; at Abington Mem. Hosp. (75-1-5)
4 Obesity; at Canonsburg Gen. Hosp. (75-1-112)
4 History of Psychiatry and Psychotherapy; at Woodville St. Hosp.; Carnegie (75-2-1)
4 Acute Renal Failure; at New Castle Country Club (75-1-109)
4 Arterial Disorders and the Lower-Extremity Peripheral Vascular Disease; at Jefferson, Philadelphia (75-1-325)
4 Fetal Monitoring; at Memorial Hosp., Philadelphia (75-1-349)
4 Clinical Hypertension; at Nason Hosp., Roaring Spring (75-1-118)
5 Veneral Diseases; at Sacred Heart Hosp., Allentown (75-1-38)
5 Hysterectomy; at St. Joseph Hosp., Lancaster (75-1-53)
5 Shock—Causes and Treatment; at McKeesport Hosp. (75-1-114)
5 Growth & Development - When to Reassure, When to Treat; at Holy Redeemer Hosp., Meadowbrook (75-1-19)
5 General and Thoracic Surgery Day; at Washington Hosp. (75-1-122)
5 Cardiac Arrhythmias—Diagnosis and Management; at New Kensington (75-2-24)
5- 6 Treatment of Acne and Other Common Skin Problems; at Pitt (75-1-129)
6 Patient with Discrete Lesion on X-ray; at Altoona Hosp. (75-1-39)
6 Problems of Adolescence; at Pottsville Hosp. (75-1-1)
6 Office Evaluation and Treatment of Hypertension; at Mercy Hosp.; Wilkes-Barre (75-1-348)
7 Stress Testing; at St. Clair Mem. Hosp., Pittsburgh (75-1-116)
7 Hodgkins Disease; at Tumor Clin. of Sharon Gen. Hosp. (75-1-135)
9-15 • Anatomy and Surgery of the Nose; by Pitt., (75-1-134)
10-14 • Advanced Diagnostic Ultrasound Training Course in Echocardiography; by Temple, Philadelphia (75-1-145)
11 Newer Diagnostic Techniques—How to & When to Use; at Abington Mem. Hosp. (75-1-5)
11 Diabetic Shock and Hyperinsulinism; at Mayview St. Hosp., Bridgeville (75-1-110)
11 Review of Common Skin Diseases; at Butler Holiday Inn (75-1-111)
11 Classical Psychoanalysis; at Woodville St. Hosp., Carnegie (75-2-1)
11 Chemotherapeutic Principles; at St. Francis Hosp., New Castle (75-1-354)
11 Venous Disorders and the Lower Extremity Medical/Surgical Aspects; at Jefferson, Philadelphia (75-1-325)
11 Diabetic Therapy; at Memorial Hosp., Philadelphia (75-1-349)
11 Diagnostic Work-up When the Only Symptom is "Headache"; New Stanton (75-1-400)
12 Office Management of Diabetes; at Geisinger, Danville (75-1-301)
12 Cardiology I. The Use of Physical Diagnosis in the Recognition of Cardiac Disorders; at Lock Haven Hospital (75-1-272)
12 Chronic Lung Disease or Pulmonary Insufficiency; at McKeesport Hosp. (75-1-114)
12 Medical Management of Rheumatic Heart Disease; at Sunbury Community Hosp. (75-1-9)
12 Rheumatoid Arthritis; at Luzerne Co. Med. Soc., Wilkes-Barre (75-2-21)
12-13 Nutrition; at Pitt (75-1-129)
13 Genetic Counselling; at Hazleton St. Gen. Hosp. (75-1-47)
13 Emergency Management of Acute Chest Pain; at Nesbitt Hosp., Kingston (75-1-309)
14 Genetics and Genetic Counselling Workshop; at Williamsport Hosp. (75-1-43)
15 Anaerobic Infections; at Armstrong Co. Mem. Hosp., Kittanning (75-1-138)
17 Nosology in Psychiatry; at Bryn Mawr Hosp. (75-1-353)
18 Newer Diagnostic Techniques—How to & When to Use; at Abington Mem. Hosp. (75-1-5)
18 Screening Procedures; Workup of an Endocrine Case; at Bryn Mawr Hosp. (75-1-352)
18 Other Psychoanalytic and Psychodynamic Theories; at Woodville St. Hosp., Carnegie (75-2-1)
18 Peripheral Vascular Disease—Elective & Emergency Surgery; Charleroi Div., Monongahela Valley Hosp. (75-1-41)
18 Pain and Discomfort in the Chest/Cardiovascular Causes; at Jefferson, Philadelphia (75-1-325)
18 Antibiotics; at Memorial Hosp., Philadelphia (75-1-349)
19 Early Detection and Management of Chronic Lung Diseases; at Allentown Hosp. (75-1-38)
19 Early Detection and Management of Chronic Lung Disease; at Allentown and Sacred Heart Hosp. Cntr. (75-1-294)
19 Treatment of Peptic Ulcer and Its Complications; at St. Joseph Hosp., Lancaster (75-1-53)
19 Cardiology II. Coronary Artery Disease: Medical vs. Surgical Management; at Lock Haven Hospital (75-1-272)
19 Acquired Heart Disease (Non-Coronary); at McKeesport Hosp. (75-1-114)
19 U.R.I. in Children; at St. John's Gen. Hosp., ADR Cntr., Pittsburgh (75-1-137)
19 Diagnosis and Treatment of Diseases of the Peripheral Circulation; at Shadyside Hosp., Pittsburgh (75-1-117)
19 Rheumatoid Arthritis—Diagnosis and Treatment; at Beaver Co. Hosp., Rochester (75-1-119)
19 Diarrhea; at Sharon Gen. Hosp. (75-1-120)
19 Complications of Pregnancy; at Soldiers & Sailors Mem. Hosp.; Wellsboro (75-1-4)
19-20 Management of Rheumatoid Arthritis Joint Aspiration—Injectionable Medications in the Office; at Pitt (75-1-129)
20 Patient with Acute Respiratory Distress; at Altoona Hosp. (75-1-39)
20 Evaluation of the Infertile Couple; at Hanover Gen. Hosp. (75-1-295)
20 Office Emergencies; at Harrisburg (75-1-124)
20 The Child Asthmatic; at Hazleton St. Gen. Hosp. (75-1-47)
21 Peptic Ulcer Disease; at Bryn Mawr Hosp. (75-1-351)
23 Cardiology Workshop—1975; at West Penn, Pittsburgh (75-1-345)
24-25 • Use of Staplers in Surgery; by Pitt (75-1-383)
25 Psychiatric Examination and Clinical Manifestations of Psychiatric Disorders; at Woodville St. Hosp., Carnegie (75-2-1)
25 Pain and Discomfort in the Chest/Pulmonary Causes; at Jefferson, Philadelphia (75-1-325)
25 Adult Respiratory Distress Syndrome; at Memorial Hosp., Philadelphia (75-1-349)
26 Liver Disease; at McKeesport Hosp. (75-1-114)
26 New Approaches to Treating Myocardial Infarcts; at St. Joseph's Hosp., Reading (75-1-346)
26 Diagnosis and Treatment of Gastrointestinal Hemorrhage; at Sunbury Community Hosp. (75-1-9)
26 Treatment of Cardiac Arrest; at Uniontown Hosp. (75-1-121)
26 X-Ray Conference, Laboratory Conference; at Washington Hosp. (75-1-122)
26-27 Drug Interactions; Incompatibilities on IV Medications; at Pitt (75-1-129)
27 Evaluation of Jaundice; at Hazleton St. Gen. Hosp. (75-1-47)
27 Neurological Complication of Visceral Malignancy; at Holy Redeemer Hosp., Meadowbrook (75-1-11)
27 Evaluation of Patient with Liver Disease; at North Hills Passavant Hosp., Pittsburgh (75-1-115)
27 Endoscopy, Clinical Applications and New Techniques; Good Samaritan Hosp., Pottsville (75-1-293)

MARCH

? Various Aspects of Arthritis and Its Management; at Mercy Hosp., Wilkes-Barre (75-1-348)
1 Crohn's Disease; at Armstrong Co. Mem. Hosp., Kittanning (75-1-138)
2 Cardiology Workshop—1975; at West Penn, Pittsburgh (75-1-345)
3- 7 • Diagnostic Ultrasound Training Course-Introductory; by Temple, Philadelphia (75-1-143)
4 Genetics; at Canonsburg Gen. Hosp. (75-1-112)
4 Schizophrenia; at Woodville St. Hosp., Carnegie (75-2-1)
4 Hypertension—Diagnosis and Treatment; at Philhaven Hosp., Lebanon (75-1-311)
4 Practical Management of Common Neurological Disorders; at New Castle Country Club (75-1-109)
4 Pain and Discomfort in the Chest/Musculo-Skeletal Causes; at Jefferson, Philadelphia (75-1-325)

4 VD in Daily Practice; at Nason Hosp., Roaring Spring (75-1-118)
4- 5 Establishing Yourself in Medical Practice; by PMS, Harrisburg (75-1-398)
5 Endocrinology—Newer Methods of Hormonal Assays and Their Practical Use; at Sacred Heart Hosp.; Allentown (75-1-38)
5 Gall Bladder Disease; at St. Joseph Hosp., Lancaster (75-1-53)
5 Gastrointestinal Disease; at McKeesport Hosp. (75-1-114)
5 Treatment of Abnormalities of Acid-Base Balance; at Holy Redeemer Hosp., Meadowbrook (75-1-19)
5 Cardiac Drugs-Use and Abuse; at Sharon Gen. Hosp. (75-1-120)
5 Endocrinology; at New Kensington (75-2-24)
5- 6 Evaluation of Surgical Risk; at Pitt (75-1-129)
6 Diabetic with Visual Edema; at Altoona Hosp. (75-1-39)
6 Neurologic Emergencies—Dx and Rx; at Hazleton St. Gen. Hosp. (75-1-47)
6 Acute Management of Burns; at Pottsville Hosp. (75-1-1)
7 Clinical Assessment of the Cell Mediated Immune System; at Geisinger, Danville (75-1-303)
7 Thyroid Nodules; at St. Clair Mem. Hosp., Pittsburgh (75-1-116)
7 Carcinoma of the Lung—Palliative and Chemotherapeutic Treatment; at Tumor Clin. of Sharon Gen. Hosp. (75-1-135)
7- 8 Medical Writing Workshop; at Institute, Philadelphia (75-1-324)
11 Management of Chronic Renal Failure; at Mayview St. Hosp., Bridgeville (75-1-110)
11 Obesity and Management; at Butler Holiday Inn (75-1-111)
11 Schizophrenia; at Woodville St. Hosp., Carnegie (75-2-1)
11 Pain and Discomfort in the Chest/Miscellaneous Causes; at Jefferson, Philadelphia (75-1-325)
11 Tongue Cancer; New Stanton (75-1-400)
12 Esophageal Disorders; at Geisinger, Danville (75-1-299)
12 Ophthalmoscopy and Other Diagnostic Aids in Diagnosis of Diseases of the Eye; at Lock Haven Hospital (75-1-272)
12 Jaundice: Differential Dx and Management; at Holy Redeemer Hosp., Meadowbrook (75-1-11)
12 New Developments in Pulmonary Embolism and Venous Thrombosis; at Temple, Philadelphia (75-1-153)
12 Jaundice: Differential Diagnosis and Management; at Sunbury Community Hosp. (75-1-9)
12 Osteoporosis; at Luzerne Co. Med. Soc., Wilkes-Barre (75-2-21)
12-13 Medical vs. Surgical Treatment—GI Bleeding; at Pitt (75-1-129)
13 Hospital Infections; at Hazleton St. Gen. Hosp. (75-1-47)
13 Practical Aspects of Fluid and Electrolyte Therapy; at Nesbitt Hosp., Kingston (75-1-309)
13-14 • Frontiers of Psychotherapy; by Temple, Philadelphia (75-1-147)
14 G.U. Tract Infection; at Williamsport Hosp. (75-1-43)
15 Pharmacology: Incompatibilities on IV Medications; at Armstrong Co. Mem. Hosp., Kittanning (75-1-138)
17-20 Fluid, Electrolyte and Acid Base Disorders; by Hahnemann, Philadelphia (75-1-22)
17-20 Sex and the Life Cycle; by Hahnemann, Philadelphia (75-1-394)
18 Calcium and Phosphorous Metabolism and Thymic Deficiencies; at Bryn Mawr Hosp. (75-1-352)
18 Paranoid Reactions; at Woodville St. Hosp., Carnegie (75-2-1)
18 Hematologic Workup Including Bone Marrow; at St. Francis Hosp., New Castle (75-1-354)
18 Surgical Aspects of Chest Pain; at Jefferson, Philadelphia (75-1-325)
18-19 TB '75 Symposia; Lung Assoc., Philadelphia (75-1-403)
19 Peptic Ulcer Disease—Recent Aspects; at Allentown Hosp. (75-1-38)
19 Large Bowel and Ano Rectal Disease; at Hanover Gen. Hosp. (75-1-295)
19 Carcinoma of the Colon; at St. Joseph Hosp., Lancaster (75-1-53)
19 Parkinsonism: Diagnosis and Management; at Lock Haven Hospital (75-1-272)
19 Evaluation of Jaundice and Liver Function Tests; at ADR Center, St. John's Hosp., Pittsburgh (75-1-137)
19 V.D. in Daily Practice; at Shadyside Hosp., Pittsburgh (75-1-117)
19 Fluid and Electrolyte Management; at Sharon Gen. Hosp. (75-1-120)
19 Common Ear Problems; at Soldiers & Sailors Mem. Hosp.; Wellsboro (75-1-4)
19-20 Practical Management—Acid Base Balance and Electrolyte; at Pitt (75-1-129)
20 Patient with Diabetes and Abnormal Lipids; at Altoona Hosp. (75-1-39)
20 Chemical Mediators in Allergic Disease: Application to Therapy; at Bryn Mawr Hosp. (75-1-350)
20 Lupus Erythematosis; at Hazleton St. Gen. Hosp. (75-1-47)
20 Orthopedics Seminar; at Memorial Hosp., Philadelphia (75-1-326)
21 Obscure Causes of Urinary Tract Infections; at Bryn Mawr Hosp. (75-1-351)
21 Fourth Annual Symposium on Sports Medicine; by Pitt (75-1-382)
25 Affective Reactions; at Woodville St. Hosp., Carnegie (75-2-1)
25 Pain and Discomfort in the Abdomen/Stomach and Duodenum; at Jefferson, Philadelphia (75-1-325)
26 Arteriography in Gastrointestinal Bleeding; at St. Joseph's Hosp., Reading (75-1-346)
26 Diagnosis and Management of Acid Base Disorders; at Sunbury Community Hosp. (75-1-9)
26 Diagnosis and Treatment of Lower Back Pain; at Uniontown Hosp. (75-1-121)
26-27 Management of Common Pediatric Problems; at Pitt (75-1-129)
27 Hand Injuries; at Hazleton St. Gen. Hosp. (75-1-47)
27 Hyperlipidemia; Good Samaritan Hosp., Pottsville (75-1-293)
27 Treatment Available for Mammary Carcinoma; at North Hills Passavant Hosp., Pittsburgh (75-1-115)
28-29 Human Sexuality and Related Problems; by Temple, Philadelphia (75-1-12)

APRIL

? • Strabismus; by Pitt (75-1-384)
1 VD in Daily Practice; at Canonsburg Gen. Hosp. (75-1-112)
1 Acute and Chronic Brain Syndromes; at Woodville St. Hosp., Carnegie (75-2-1)
1 Pain and Discomfort in the Abdomen, Biliary Tract and Pancreas; at Jefferson, Philadelphia (75-1-325)
1 Modern Concepts and Treatment of Major Types of Epilepsy; at Nason Hosp., Roaring Spring (75-1-118)
2 Genetic Counseling; at Allentown and Sacred Heart Hosp. Cntr. (75-1-294)
2 Genetic Counseling (What It is, Who Needs It, and How to Get It); at Sacred Heart Hosp., Allentown (75-1-38)
2 Neurologic Problems in Family Practice; at Geisinger, Danville (75-1-302)
2 Cardiac Resuscitation; at Easton Hosp. (75-1-10)
2 Coronary Arteriography; at St. Joseph Hosp., Lancaster (75-1-53)
2 Recent Advances in Evaluation of Endocrinopathies; at Sharon Gen. Hosp. (75-1-120)
2 E. R. Medicine—Management of the Acute Trauma Patient; at New Kensington (75-2-24)
2- 3 Approach to Hematuria Urinary Tract Infections; at Pitt (75-1-129)
3 Child with Lymphadenopathy; at Altoona Hosp. (75-1-39)
3 Evaluation and Uses of New Antibiotic Medications; at Pottsville Hosp. (75-1-1)
3 Practical Aspects and Use of Pulmonary Function Tests with Their Evaluation in the Family Practitioners Office; at Mercy Hosp., Wilkes-Barre (75-1-348)
3- 4 CPR Instructors' Training Course; by Heart Assn., Hershey (75-1-378)
3- 4 • Fifth Annual Seminar (Spring Series) and Workshop in Diagnostic and Operative Laparoscopy; by Pitt (75-1-381)
4 Dermatological Manifestations of Internal Disease; at St. Clair Mem. Hosp., Pittsburgh (75-1-116)
4 Leukemia; at Tumor Clin. of Sharon Gen. Hosp. (75-1-135)
5 Diagnosis, Stages and Treatment of Carcinoma of the Prostate; at Armstrong Co. Mem. Hosp., Kittanning (75-1-138)
5 Acute Infectious Disease; at Sharon Gen. Hosp. (75-1-120)
7-11 • Advanced Diagnostic Ultrasound Training Course in Abdominal Scanning; by Temple, Philadelphia (75-1-144)
8 Surgical Diseases of the Thyroid Gland; at Butler Holiday Inn (75-1-111)
8 Acute and Chronic Brain Syndromes; at Woodville St. Hosp., Carnegie (75-2-1)
8 Management of Common Pediatric Problems; at St. Francis Hosp., New Castle (75-1-354)
8 Pain and Discomfort in the Abdomen, Colon and Anal-Rectal Area; at Jefferson, Philadelphia (75-1-325)
8 Blood Transfusions and Blood Substitutes; New Stanton (75-1-400)
9 Medical Audit Case Study; at Lock Haven Hospital (75-1-272)
9 Treatment of Peripherovascular Disorders; at Holy Redeemer Hosp., Meadowbrook (75-1-19)
9 Common Skin Infections; at Sunbury Community Hosp. (75-1-9)
9 Issues in Medical Education; at Luzerne Co. Med. Soc., Wilkes-Barre (75-2-21)
9-10 Back Ache—Acute vs. Chronic; at Pitt (75-1-129)
10 Renal Calculi; at Hazleton St. Gen. Hosp. (75-1-47)
10-12 • Diagnosis & Management of Glaucoma; at Wills Eye Hosp., Philadelphia (75-1-7)
10 Practical Office Ophthalmology; at Nesbitt Hosp., Kingston (75-1-309)
11-12 Public Speaking Workshop; at Institute, Philadelphia (75-1-323)

11	Respiratory Failure in Infancy and Childhood; at Williamsport Hosp. (75-1-43)
12	Painful Hand; at Allentown-Sacred Heart Hosp. Cntr. (75-1-375)
14-25	Workshops in Respiratory Intensive Care; at Hahnemann, Philadelphia (75-1-21)
15	Epilepsy and Mental Retardation; at Woodville St. Hosp., Carnegie (75-2-1)
15	Pain and Discomfort in the Abdomen, Genito-Urinary Tract; at Jefferson, Philadelphia (75-1-325)
16	Initial Care, Rehabilitation of "Stroke"; at Aliquippa Hosp. (75-1-119)
16	Sleep Disorders; at Allentown Hosp. (75-1-38)
16	Disorders of Coagulation; at St. Joseph Hosp., Lancaster (75-1-53)
16	Musculoskeletal Problems as Seen in Office Practice; at Temple, Philadelphia (75-1-15)
16	Thyroid Function Tests, Interpretations and Drug Interference; ADR Center, St. John's Hosp., Pittsburgh (75-1-137)
16	Office Management of the Diabetic; at Shadyside Hosp., Pittsburgh (75-1-117)
16	Diagnosis and Treatment of Liver Disorders; at Soldiers & Sailors Mem. Hosp.; Wellsboro (75-1-4)
16-17	Recognition of Peripheral Neuropathies; at Pitt (75-1-129)
16-18	Echocardiography in Its Clinical Setting; by Amer. Coll. of Cardiology, Philadelphia (75-1-290)
17	Patient with Proteinuria, Pathologic Fracture; at Altoona Hosp. (75-1-39)
17	Allergic Respiratory Disease; Rhinitis/Asthma; at Bryn Mawr Hosp. (75-1-350)
17	Reconstructive Surgery: Burns, Cleft Lips and Palate, Soft Tissue Deformities; at Hanover Gen. Hosp. (75-1-295)
17	You Asked For It!; at Polyclinic Hosp., Harrisburg (75-1-124)
17	Bleeding and Clotting Time Disorders; at Hazleton St. Gen. Hosp. (75-1-47)
17-18	CPR Instructors' Training Course; by Heart Assn., Philadelphia (75-1-377)
17-18 •	Hemiplegic Rehabilitation; at Temple, Philadelphia (75-1-148)
18	Clinical Science/Surgery; at Bryn Mawr Hosp. (75-1-351)
19	Neurology: Anatomy and Neurological Testing; at Armstrong Co. Mem. Hosp., Kittanning (75-1-138)
21	Community Mental Health; at Bryn Mawr Hosp. (75-1-353)
22	Genetic Aspects of Endocrine Disease; at Bryn Mawr Hosp. (75-1-352)
22	Anxiety and Conversion Reactions; at Woodville St. Hosp., Carnegie (75-2-1)
22	Pain and Discomfort in the Abdomen, Abdominal Pain in the Pediatric Age Group; at Jefferson, Philadelphia (75-1-325)
22-23	TB '75 Symposia; Lung Assoc., Pittsburgh (75-1-403)
22-24	Optimal Standards of Care in Cardiac Emergencies; by Amer. Coll. of Cardiology, Philadelphia (75-1-291)
23 •	Staufer Lecture (Radiology); at Temple, Philadelphia (75-1-188)
23	Immunotherapy of Cancer; at St. Joseph's Hosp., Reading (75-1-346)
23	Pre- and Post-operative Evaluation and Management; at Sunbury Community Hosp. (75-1-9)
23	Congestive Heart Disease; at Uniontown Hosp. (75-1-121)
23-24	Functional Bowel Syndromes; at Pitt (75-1-129)
24	GI Bleeding; at Hazleton St. Gen. Hosp. (75-1-47)
24	Indications for Tonsillectomy; at North Hills Passavant Hosp., Pittsburgh (75-1-115)
24	The Physical Diagnosis of the Cardiovascular System; Good Samaritan Hosp., Pottsville (75-1-293)
24-26	Fourth Annual Scientific Assembly, Pa. Chapter, Amer. Coll. of Emergency Phys., Philadelphia (75-1-313)
24-26 •	Third Annual Course on Oculo-Plastic Surgery; at Wills Eye Hosp., Philadelphia (75-1-18)
25-26	18th Annual Lectureship, Pa. Assoc. of Blood Banks; at Host Inn, Harrisburg (75-1-306)
28-May 16 •	Emergency Room Medicine (Preceptor Program); at Temple, Philadelphia (75-1-146)
29	Dissociative Reaction and Phobic Reaction; at Woodville St. Hosp., Carnegie (75-2-1)
30	Goiter Differential Diagnosis and Treatment; at Geisinger, Danville (75-1-300)
30	Diagnosis and Treatment of Pulmonary Embolism; at St. Joseph Hosp., Lancaster (75-1-53)
30-May 1	Hay Fever and Hives; at Pitt (75-1-129)
30-May 2 •	Ophthalmic Micro-surgery; by Pitt (75-1-385)

MAY

?	Common Neurological Problems Seen By the Family Physician; at Mercy Hosp., Wilkes-Barre (75-1-348)
1	Hyperkinetic Child; at Altoona Hosp. (75-1-39)
1	Preoperative Evaluation and Sedation—(Anesthesiologist); at Hazleton St. Gen. Hosp. (75-1-47)
1	Management of Drug Eruption; at Pottsville Hosp. (75-1-1)
1- 2 •	Nuclear Medicine Review; by Pitt (75-1-386)
1- 3	Main Line Med. Conference; at Bryn Mawr Hosp. (75-1-296)
2	Hemolytic Anemias; at St. Clair Mem. Hosp., Pittsburgh (75-1-116)
2	Carcinoma of the Cervix and Uterus; at Tumor Clin. of Sharon Gen. Hosp. (75-1-135)
2- 3	Principles of Medical Practice Management; by PMS, Harrisburg (75-1-397)
2- 4	Annual Meeting, Pa. Soc. of Anesthesiologists; at Penn Harris Motor Inn, Camp Hill (75-1-297)
3	7th Annual Conference—Special Child-Behavior Problems; at Geisinger, Danville (75-1-305)
3	Early Diagnosis and Treatment of Carcinoma of the Breast; at Armstrong Co. Mem. Hosp., Kittanning (75-1-138)
5- 7 •	Ophthalmic Micro-surgery; by Pitt (75-1-385)
6	IV Fluid Management for the Practicing Physician and Practical Approach to Acid Base Balance; at Canonsburg Gen. Hosp. (75-1-112)
5- 9	General Medicine Reviews; by Hahnemann, Philadelphia (75-1-23)
5- 9 •	Advanced Diagnostic Ultrasound Training Course in Echocardiography; by Temple, Philadelphia (75-1-145)
7	Backache; at New Kensington (75-2-24)
6	Obsessive-Compulsive Reaction and Neurotic Depressive Reactions; at Woodville St. Hosp., Carnegie (75-2-1)
6	Abdominal Pain; at Philhaven Hosp., Lebanon (75-1-311)
6- 9	24th Annual Pediatric Seminar; by St. Christopher's Hosp., Philadelphia (75-1-18)
6- 9	Emergencies in Pediatric Practice—24th Annual Pediatric Seminar; at St. Christopher's Hosp. for Children, Philadelphia (75-1-327)
7	Management of Benign Intractable Pain Syndromes; at Sacred Heart Hosp., Allentown (75-1-38)
7	Obesity—Facts and Fancy Concerning Causation & Treatment; at Holy Redeemer Hosp., Meadowbrook (75-1-19)
7	Management of Benign Intractable Pain; at Temple, Philadelphia (75-1-14)
7-10	Critical Care Medicine (9th Annual Symposium); by Pitt (75-1-388)
8	Recent Innovations in Radiologic Diagnosis; at Hazleton St. Gen. Hosp. (75-1-47)
8	Management of the Comatose Patient; at Nesbitt Hosp., Kingston (75-1-309)
8- 9 •	Pediatric Ophthalmology Symposium; by Temple, Philadelphia (75-1-17)
9	Evaluation of Gallbladder Disease and Current Therapy; at Williamsport Hosp. (75-1-43)
9-10 •	Pediatric Otolaryngology; by Pitt (75-1-387)
9-11	CPR Instructors' Training Course; by Heart Assn.; Pittsburgh (75-1-379)
12-14 •	Recent Developments in Medical Oncology; ACP, Philadelphia (75-1-2)
13	Personality Disorders; at Woodville St. Hosp., Carnegie (75-2-1)
13	Indications for Coronary Angiography; New Stanton (75-1-400)
14	Stings from Winged Things; at Hanover Gen. Hosp. (75-1-295)
14	Surgery for Peripheral Vascular Disease; at St. Joseph Hosp., Lancaster (75-1-53)
14	Office Dermatology; at Temple, Philadelphia (75-1-16)
14	Syndromes of Hypercalcemia; at Luzerne Co. Med. Soc., Wilkes-Barre (75-2-21)
15	Office Patient with Written Problem; at Altoona Hosp. (75-1-39)
15	Immunology I; at Hazleton St. Gen. Hosp. (75-1-47)
15-16 •	Concepts and Implications of Sensory Feedback Therapy; at Temple, Philadelphia (75-1-149)
16	"Alan Parker Memorial Lecture"—Surgery; at Bryn Mawr Hosp. (75-1-351)
17	Chronic Obstructive Lung Disease; at Armstrong Co. Mem. Hosp., Kittanning (75-1-138)
20	Clinical Science/Pediatrics; at Bryn Mawr Hosp. (75-1-352)
20	Sexual Deviations; at Woodville St. Hosp., Carnegie (75-2-1)
20	Cardiac Rehabilitation; at Geisinger, Danville (75-1-304)
20	Evaluation of Dizziness; at St. Francis Hosp., New Castle (75-1-354)
21	Allergic Problems in Childhood; at Allentown Hosp. (75-1-38)
21	Allergic Problems in Childhood; at Allentown and Sacred Heart Hosp. Cntr. (75-1-294)

21 Office Endocrinology; at Temple, Philadelphia (75-1-13)
21 Symposium on Head and Neck Cancer; at Pitt (75-1-380)
21 Modern Management of Common Skin Disorders; ADR Center, St. John's Hosp., Pittsburgh (75-1-137)
21 Immunology and Prophylaxis of Allergic Rhinitis, Asthma, etc., at Beaver Co. Hosp., Rochester (75-1-119)
21 Fluid Replacement; at Soldiers & Sailors Mem. Hosp.; Wellsboro (75-1-4)
22 Therapeutic Applications of Immunology: Tissue Grafts/Transplants/Tumors; at Bryn Mawr Hosp. (75-1-350)
22 Immunology II; at Hazleton St. Gen. Hosp. (75-1-47)
22 Operable Thyroid Disease; at North Hills Passavant Hosp., Pittsburgh (75-1-115)
22-24 • Annual Conference of PAO&O; at Bedford Springs Hotel, Bedford (75-1-6)
27 Alcoholism; at Woodville St. Hosp., Carnegie (75-2-1)
28 Leukemia; at St. Joseph Hosp., Lancaster (75-1-53)
28 Surgical Management of Acquired Heart Disease; at St. Joseph's Hosp., Reading (75-1-346)
28 Immunologic Tests and Interpretations; at Uniontown Hosp. (75-1-121)
29 Immunology III; at Hazleton St. Gen. Hosp. (75-1-47)
29 Symposium on Pneumoconiosis with Interpretation of Pulmonary Function Testing; Good Samaritan Hosp., Pottsville (75-1-293)

JUNE

2- 6 • Diagnostic Ultrasound Training Course-Introductory; by Temple, Philadelphia (75-1-143)
3 Addictions; at Woodville St. Hosp., Carnegie (75-2-1)
3 Office Gynecology; at Nason Hosp., Roaring Spring (75-1-118)
4 Diagnosis and Treatment of Drug Overdose; at Easton Hosp. (75-1-10)
5 Changing Concepts in Contraceptive Techniques; at Pottsville Hosp. (75-1-1)
6 Newborn Emergencies; at Nason Hosp., Roaring Spring (75-1-118)
6 Carcinoma of the Breast; at Tumor Clin. of Sharon Gen. Hosp. (75-1-135)
7 Prevention, Diagnosis and Treatment—Carcinoma of the Lung; at Armstrong Co. Mem. Hosp., Kittanning (75-1-138)
9 Changing Concepts in Contraception; at Luzerne Co. Med. Soc., Wilkes-Barre (75-2-21)
10 Psychosomatic Medicine; at Woodville St. Hosp., Carnegie (75-2-1)
10 Treatment of Breast Cancer; at St. Francis Hosp., New Castle (75-1-354)
10 Diabetes Mellitus—Recent Advances, Treatment; New Stanton (75-1-400)
12-14 • Contemporary Problems in Surgery; by Pitt (75-1-389)
13 Immunology and Allergy Workshop; at Williamsport Hosp. (75-1-43)
14 Mechanisms of Diarrhea with Implications for Treatment at Sacred Heart Hosp., Allentown (75-1-38)
18 Hypnosis; at Bryn Mawr Hosp. (75-1-353)
18-31 • Review Seminar for Foreign Medical Graduates; by Hahnemann, Philadelphia (75-1-396)
17 Psychiatric Emergencies; at Woodville St. Hosp., Carnegie (75-2-1)
18 Dermatology; at Allentown Hosp. (75-1-38)
18 Immunologic Tests and Interpretations; at St. John's Gen. Hosp., ADR Cntr., Pittsburgh (75-1-137)
18 EKG (Simplified Interpretation); at Soldiers & Sailors Mem. Hosp., Wellsboro (75-1-4)
19 Pancreatic Disease; at Hanover Gen. Hosp. (75-1-295)
24 Unusual Psychiatric Disorders; at Woodville St. Hosp., Carnegie (75-2-1)
25 Hypertension—Diagnosis and Prescription; at St. Joseph's Hosp., Reading (75-1-346)

JULY

1 Individual Psychotherapy: Psychoanalytic Behavior, Client-Centered, Hypnosis, Direct Analysis; at Woodville St. Hosp., Carnegie (75-2-1)
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M E R S
(Medical Education Resource Service)

A new catalog is being published that will include the various media resources that are available in the major medical institutions in Pennsylvania. Many of these items are available for loan on request. The catalog will explain the specific provisions regarding loan and will include the name of the person to contact to complete the loan arrangements.

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The Pennsylvania Medical Continuing Education Institute is strongly committed to continuing medical education which pays off directly in better patient care. To this end, the Institute is publishing the program that has been developed by the University of Wisconsin—Madison for general and family practitioners.

EDUCATIONAL RESOURCE INDEX — REQUEST FORM

looking for a program that is tailored to your needs?.....

I. Subject Areas—Disease Categories (Select 1 or 2)

- ☐ Infective & parasitic diseases
- ☐ Malignant neoplasms not of blood
- ☐ Neoplasms of blood & lymphatic
- ☐ Benign neoplasms
- ☐ Diabetes
- ☐ Obesity
- ☐ Other endocrine, metabolic & nutritional diseases
- ☐ Diseases of the blood & blood-forming organs
- ☐ Mental diseases
- ☐ Social problems
- ☐ Diseases of central nervous system
- ☐ Eye & ear problems
- ☐ Rheumatic fever & heart disease
- ☐ Hypertension
- ☐ Ischemic heart disease
- ☐ Other heart diseases
- ☐ Cerebrovascular disease
- ☐ Other vascular diseases
- ☐ Cardiovascular unspecified
- ☐ Acute respiratory infections
- ☐ Bronchitis, emphysema, asthma
- ☐ Other respiratory diseases
- ☐ Respiratory system unspecified
- ☐ Oral cavity, salivary glands, jaws
- ☐ Esophagus, stomach & duodenum
- ☐ Intestine & peritoneum
- ☐ Liver, gallbladder & pancreas
- ☐ Urinary system
- ☐ Male genital organs
- ☐ Breast & female genital organs
- ☐ Complication of pregnancy & puerperium
- ☐ Delivery
- ☐ Diseases of the skin & subcutaneous tissue
- ☐ Arthritis & rheumatism
- ☐ Muscular-skeletal system, connective tissue
- ☐ Congenital anomalies
- ☐ Perinatal morbidity & mortality
- ☐ Symptoms & ill-defined conditions
- ☐ Fractures, dislocations, sprains, strains
- ☐ Other trauma including burns
- ☐ Adverse drug effects & poisoning
- ☐ Other adverse effects
- ☐ General examination
- ☐ Radiological examination
- ☐ Well baby & child care
- ☐ Pre-natal examination
- ☐ Post-partum
- ☐ Contraception
- ☐ Other examinations without illness
- ☐ Post-operative care & rehabilitation
- ☐ Practice management
- ☐ General programs
- ☐ Tours & cruises with CME programs
- ☐ Population & ecology
- ☐ Sports medicine
- ☐ Preventative medicine
- ☐ Geriatric problems
- ☐ Adolescent medicine

II. Learning Method(s)

- ☐ Conferences, Workshops *(1 to 9 days long)*
- ☐ Traineeships *(10 days or more)*
- ☐ Home Study Materials *(e.g., audiotapes, correspondence courses)*

III. Time & Location (for conferences, workshops & traineeships)

A. Time Preferences:

☐ Any time during the next 12 months

OR during one or more of these months:

- ☐ January
- ☐ February
- ☐ March
- ☐ April
- ☐ May
- ☐ June
- ☐ July
- ☐ August
- ☐ September
- ☐ October
- ☐ November
- ☐ December

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☐ Anywhere in the United States (including tours and cruises)

OR in these states:

_____

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DISPLAY
SHELVES

pennsylvania medicine

February 1975

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE

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pennsylvania medicine

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February 1975 Volume 78, Number 2

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THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON

APR 11 1975

medigram

MEMBERS TO RECEIVE REPORT ON MALPRACTICE A report from the Society's Ad Hoc Committee on the Medical Malpractice Problem will be mailed to each member following the committee's second meeting January 30. In establishing the committee at its January 15 meeting, the Board of Trustees asked that progress reports reach the members through direct mailings as well as by way of regular communications channels.

SOCIETY TO SEEK PHYSICIAN DELEGATION LEGISLATION The Board adopted a recommendation of the Council on Education and Science that the Society continue to seek amendments to the Medical Practice Act which would clearly permit the delegation of specific duties to non-physician personnel. Although H.B. 1468, "the physician's assistant bill," was passed by the Legislature, it was vetoed by Governor Shapp on technical grounds that it amended the old, not the new Medical Practice Act. Also vetoed on technical grounds was S.B. 1166, known as the "child abuse bill," which was passed by the Legislature late in 1974. Both bills are expected to be reintroduced in the present Legislature.

COOPERATIVE WITHIN REACH OF GOAL The Pennsylvania Medical Cooperative is within 200 members of reaching its charter membership goal of 2,000 as the January 31 deadline approaches. Those joining after February 1 will pay a $200 membership fee. The Council on Professional Relations and Services meets February 8 to assess the future of the Cooperative.

STATE SOCIETY OFFICERS ON BLUE SHIELD BOARD At its January 15 meeting the Society's Board of Trustees named the following as Blue Shield Corporation members at large: Drs. John B. Lovette, speaker of the House of Delegates; D. Ernest Witt, vice speaker; and David W. Clare, Tenth District trustee. Fourteen Society officials are members of the Blue Shield Corporation. Robert E. Rinehimer, president of Pennsylvania Blue Shield, recently was elected vice chairman of the board of directors of the National Association of Blue Shield Plans.

SOCIETY REVIEW WILL COST The Board of Trustees, on the recommendation of the Council on Medical Service, has ended free peer review for third party payers in disputed claims cases. Heretofore the Pennsylvania Medical Care Program, the Society's review mechanism, charged only administrative costs. In the future, third party payers will be billed for review at $35 per hour per physician.

CONGRESS REACTS TO MALPRACTICE CRISIS Two bills concerning the medical malpractice insurance crisis have been introduced in the United States Senate. Sen. Gaylord Nelson has introduced S.B.188, which would establish in the Department of Health, Education, and Welfare (HEW) a national medical

malpractice development fund to provide reinsurance to protect primary insurers against catastrophic malpractice losses. The measure also would require HEW to conduct studies of malpractice, including alternatives to the present system of settling malpractice claims. Senators Daniel Inouye and Edward Kennedy have introduced S.B.215, which would establish a federal system of compensation for injuries incurred as a result of medical treatment. The program, patterned after workmen's compensation, would provide for compensation by the government without proof of provider negligence. See page 9--the President's Page--for a review of the State Society's activities in the crisis.

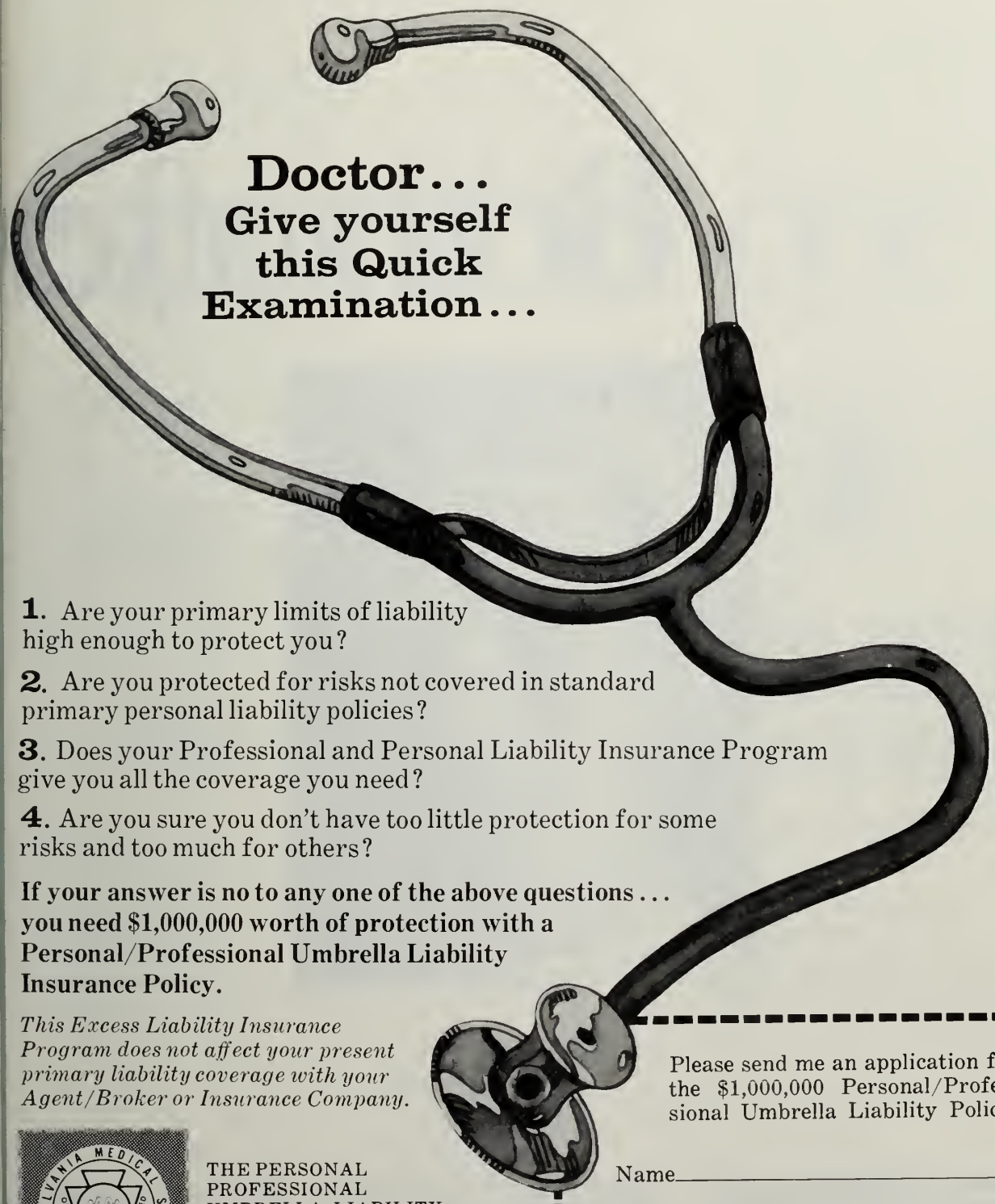
DISABLED DOCTOR CONFERENCE SCHEDULED The AMA's Department of Mental Health will convene a national conference on "The Disabled Doctor" April 11 and 12, at the St. Francis Hotel, San Francisco. Conference goal is to define the profession's responsibility to help the disabled physician and protect the public. For information write to the Department of Mental Health at AMA headquarters.

MANAGEMENT WORKSHOP FOR NEW PHYSICIANS The State Society and the AMA will sponsor a workshop for new physicians March 4 and 5 at the Harrisburg Host Inn. Conomikes Associates, management consultants, will conduct a program to give practical information on the business and administrative problems of beginning a practice. Contact the Council on Education and Science for further information.

COUNTY SOCIETIES CAN EARN MORE County medical societies who report their AMA dues by February 28 will receive 40 percent of the AMA rebate to the State Society, which amounts to one half of one percent above the prime interest rate on certificates of deposit. The AMA initiated the rebate pilot program to encourage early reporting of dues money. The current financial crisis of the AMA makes prompt reporting doubly important.

FREE LIBRARY SERVICE ENDS Free library service for the State Society and its members at Harrell Library at Hershey Medical Center ends February 1, 1975. The Board of Trustees acted to discontinue financial support for the service because it has been used less and less each year. Requests for a literature search or copies of articles will be filled after February 1 but must be paid for by the individual. Physicians may still be able to receive library service free through their local hospital libraries by using the National Library of Medicine network and having the hospital channel their requests through the medical libraries in their areas--University of Pittsburgh, Milton S. Hershey Medical Center, or the College of Physicians in Philadelphia.

DRUG COST RULES POSTPONED The deadline for comments on HEW's Maximum Allowable Cost (MAC) regulations has been extended to February 15. The proposed rules apply to medicare, medicaid and maternal and child health programs and would limit reimbursement for all drugs to actual cost plus a dispensing fee.



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Both often

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequ and/or severity of grand mal seizures require increased dosage of standard convulsant medication; abrupt withdr may be associated with temporary increase in frequency and/or severity o seizures. Advise against simultaneou gestion of alcohol and other CNS dep sants. Withdrawal symptoms (similar those with barbiturates and alcohol) h occurred following abrupt discontinu (convulsions, tremor, abdominal and cle cramps, vomiting and sweating). addiction-prone individuals under ca

respond to one

According to her major
ptoms, she is a psychoneu-
: patient with severe
ety. But according to the
ription she gives of her
ngs, part of the problem
sound like depression.
is because her problem,
ough primarily one of ex-
ve anxiety, is often accom-
ed by depressive symptom-
ogy. Valium (diazepam)
provide relief for both—as
xcessive anxiety is re-
d, the depressive symp-
associated with it are also
relieved.
There are other advan-
s in using Valium for the
agement of psychoneu-
anxiety with secondary
essive symptoms: the
hotherapeutic effect of
ım is pronounced and
l. This means that im-
ement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

illance because of their predisposi-
habituation and dependence. In
ancy, lactation or women of child-
ng age, weigh potential benefit
st possible hazard.

utions: If combined with other psy-
opics or anticonvulsants, consider
ully pharmacology of agents em-
d; drugs such as phenothiazines,
tics, barbiturates, MAO inhibitors
her antidepressants may potentiate
ion. Usual precautions indicated in
ts severely depressed, or with latent
ssion, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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nicotinic acid therapy

IMMEDIATE RELEASE		GRADUAL RELEASE
LIPO-NICIN/100 mg. Each blue tablet contains: Nicotinic Acid .....100 mg. Niacinamide ..... 75 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 5 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000	**LIPO-NICIN/250 mg.** Each yellow tablet contains: Nicotinic Acid .....250 mg. Niacinamide ..... 75 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 3 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000	**LIPO-NICIN/300 mg.** Each timed-release capsule contains: Nicotinic Acid .....300 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 3 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

WRITE FOR LITERATURE AND SAMPLES
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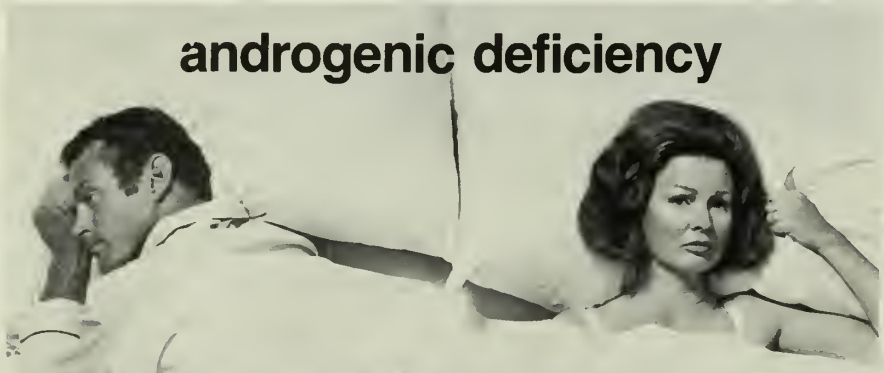
REFER TO PDR

When **impotence** *due to*

androgenic deficiency



is driving them apart

Android®-5 MUQETS BUCCAL Tabs
Android®-10 ORAL Tabs
Android®-25 ORAL Tabs

Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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REFER TO PDR

The rectal thermometer & NEOPAP® SUPPRETTES™

(acetaminophen suppositories)

a rational regimen for childhood fever.

NEW 5gr STRENGTH

Antipyretic for children

- No salicylate side effects
- Store without refrigeration
- Convenient rectal administration
- Available only by prescription
- Grooved for one-half suppository administration

Description: NEOPAP SUPPRETTES are available for rectal administration in potencies of 2 gr or 5 gr of acetaminophen in NEOCERA® Base (a unique blend of water-soluble Carbowaxes*).

Indications: For management of fever associated with common childhood infections.

Contraindications: Sensitivity to acetaminophen or the suppository base.

Warnings: Not for use in children under three years of age. Should not be administered repeatedly to patients with pulmonary, cardiac, renal, or hepatic disease.

Precautions: Prolonged administration may result in such withdrawal symptoms as restlessness and excitement when the drug is discontinued.

Adverse Reactions: No significant adverse reactions have been reported with NEOPAP (acetaminophen) SUPPRETTES. However, adverse reactions associated with administration (usually chronic) of this drug have included the following:

Blood: Cyanosis, methemoglobinemia, sulfhemoglobinemia, and hemolytic anemia; neutropenia, leukopenia, and pancytopenia.

Allergic: Skin eruptions, urticaria, fever.

Other: Hypoglycemia, CNS stimulation, jaundice.

Dosage and Administration: Children 3 to 6 years of age: One 2 gr suppository rectally 3 or 4 times daily; not to exceed 8 grains per day.

Children 6 to 12 years of age: One 5 gr suppository rectally 3 or 4 times daily; not to exceed 20 grains per day.

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president's page

MALPRACTICE CRISIS—

State Society acts to seek relief

While the recession has hastened the arrival of the malpractice crisis, all its elements were long in the making. Chief of these, to my mind, has been the well-intended but unethical, immoral, and fiscally irresponsible use of malpractice premiums to finance life insurance benefits, disability insurance benefits and health insurance benefits. The use of malpractice insurance to finance a social security program is resulting in judgments and premiums which society cannot support. We sympathize with the patient incapacitated by disease or injury, but this emerging *de facto* patient compensation program, improperly financed under the guise of the malpractice insurance system as we now know it, is destroying the ability of the physician to take care of the sick. Ultimately it will deny needed treatment to the citizens of Pennsylvania. There is only so much risk that the doctor and his patients together, can bear.

Nowhere is this more poignantly described than in the letter (published in the *New York Times* late last year) from Dr. Rosamond Kane of Rye, New York, to her patients concerning her malpractice insurance. Dr. Kane said:

> "You all know that because I teach and run the Children's Foot Clinic at Presbyterian Hospital, I maintain only a small practice. It has recently averaged 260 patient visits per year. $14,000 divided by 260 is approximately $54. It would cost me more than $60 per patient visit next year and that is a price that neither you nor I can afford."

And with that, Dr. Kane retired from private practice to the detriment of her patients.

In the days and weeks ahead your elected leaders will be dealing with several major aspects of this crisis. First, we have a responsibility to all 13,000 members of the Society. Some of you have asked what you can do to help. One thing is certain, we need information. We need to know how the present malpractice premiums, etc., are impacting on your practice, on your group. We need to know what it is costing your patients. We need to know what your contingency plans are should premiums go up 100, 200, or 300 percent or should coverage become unavailable. This information will be vital as we go to the legislature and the courts to seek relief. We need facts.

Second, we have a special obligation to the nearly 4,000 of you who have accepted in good faith the Society's endorsement of the Argonaut program. As you recall, the key features of the program are:

1. Open to all members subject to Society review.
2. Five-year coverage cannot be cancelled or non-renewed (except for non-payment of premium) without consent of the State Society.
3. Primary coverage available up to and including limits of $1,000,000.

Now, based on a letter dated December 24, Argonaut wishes to change the program and its written agreement. Among the proposed changes:

1. Limit the program to members who (a) become associated with physicians already insured by Argonaut; (b) leave internships or residencies and enter private practice; or (c) enter Pennsylvania from other states or countries.
2. File for a substantial rate increase.
3. When the rate filing is approved, switch on all renewals and new business to a "claims made" contract. (Such a change would require Insurance Department approval.)
4. Following a specified date, issue all new and renewal policies at a level limit of $200,000/$600,000.

Let me comment on points three and four. All present Argonaut policies are issued on an "occurrence" basis. This means that long after you have ceased to buy insurance from Argonaut, (upon retirement) you or even your estate are still covered for that policy year. This is extremely important under current Pennsylvania law, for the statute of limitations runs two years from discovery! Breathes there the surgeon who has not dreamed of a sponge or clamp come to haunt him in his retirement. Present policies defend him. Under the new "claims made" policy, he would be covered only so long as he continues to buy policies from Argonaut, or buys extra drop-back coverage.

The attempt to limit primary coverage to $200,000/$600,000 places the burden of securing additional coverage back on the doctor. He must seek an umbrella policy to reach the desired million dollar coverage.

Since one-third of our members are insured with Argonaut, let me give you some additional background. By the end of 1974, Argonaut was one of the principal malpractice insurance carriers in the United States. It had affiliated with medical societies in New York, Pennsylvania, Florida, Idaho, Hawaii, and Massachusetts. It was writing in many other states without formal medical society endorsement. As of January it is either pulling out or drastically reducing its commitments nationwide. Demands on PMS for changes in its contract came after an alleged purge of Argonaut top brass by the parent company, Teledyne, December 2. Sent in to run the company was Jerrold V. Jerome, vice president-finance, of Teledyne. The parent conglomerate is reported to have taken heavy losses in its investment program.

As I reported to the Board of Trustees on January 15, the ripple effects of a contracting economy have reached the malpractice insurance industry and brought it crashing down upon us. The decline in the stock market has adversely affected the reinsurance market, which bears much of the risk for coverage in malpractice judgments. Reinsurers wish to reduce their risks in line with their declining assets. In a like manner, primary insurers such as Argonaut must limit their exposure to match lower levels of reserves.

It is also true that Argonaut has taken losses here in the Commonwealth. The projected final claim count for the PMS program has been climbing. 1971, 110; 1972, 299; and 1973, 460.

Because great crises also offer great opportunities, I have, with the approval of the Board of Trustees, appointed an ad hoc committee to coordinate our response to this challenge. Joining me on the committee are: David S. Masland, M.D., president elect; Donald E. Harrop, M.D., chairman of the Council on Governmental Relations and the Commission on Forensic Medicine; and John J. Danyo, M.D., chairman of the Commission on Professional Liability Insurance. Our first meeting is scheduled for January 23. Our goal is to hammer out a package of proposals and priorities which will be implemented promptly. We will not delay for meeting dates, but will obtain proper authorization to proceed upon each item as soon as the committee feels it has been properly developed. Included will be public education, legislation, judicial reform, insurance industry changes and girding up of disciplinary machinery within the profession. We must and we will eliminate the obstructions placed in the path of the proper practice of medicine by so-called "due process of law" and those who have been allowed to distort the truth for their own ends for too long. Again, I welcome your ideas. Let me hear from you.

Concurrently we will continue our negotiations with Argonaut. I promise you that, with the concurrence of the Executive Committee, I will not agree to amendments to our contract until I am convinced they are the very best deal we can get under the circumstances. I will continue this conversation with you again next month.

A. Reynolds Crane, M.D.
President

Leonard Bachman, M.D., named secretary of health

Leonard Bachman, M.D., newly appointed secretary of health and Governor Shapp's health services director since 1972, intends to tap "one of the greatest resources we have in the state and in the nation—the medical profession" for assistance in solving the problems ahead.

His dual role makes Dr. Bachman responsible for administering the state's department of health with its 2,000 employees and for developing overall planning for the health needs of the people.

At ease despite a crowded schedule of appointments extending into the night and in his shirtsleeves, Dr. Bachman discussed health care planning for the Commonwealth. He sees the Comprehensive Health Care Act, including cost containment provisions, certificate of need requirements, and establishment of a planning council as having priority in the State Legislature early in the current session. "We're fortunate we're as far along as we are in discussions of such legislation in view of the enactment of the national legislation," he said, referring to passage of the Health Planning Act by the Ninety-Third Congress (see article on page 14).

Dr. Bachman acknowledged a shortage of medical services, but indicated that long-range solutions lie in education. While he expects the Legislature to study bills dealing with the alleged physician shortage, he sees answers through education, and pointed to the Governor's Committee on Education of Health Professionals, in the Department of Education, as having better means for finding the solutions.

"More family physicians is the greatest need," he said. "This is a vital, new medical specialty, but with the old-fashioned physician's interest in the patient in his totality. If these busy doctors are to give patients the time they need, they must have support personnel to perform routine tasks—particularly when the practice is located in an area with few physicians."

Dr. Bachman sees the development of community health centers as a means to providing care in areas with an immediate acute physician shortage. There are eleven of these community operated centers in the state. The community provides the facility, and physicians are supported by paraprofessionals in caring for patients and by personnel trained in business management, so that physicians can concentrate on patients' health problems. The Department of Health has provided some funds to help start health centers in the Commonwealth, but the intent is that they can be self-supporting.

Improving emergency health services is high on the secretary's list of priorities. "The department is moving ahead in the area of emergency services," Dr. Bachman said. "We're very fortunate to have Dr. Muller (Arnold Muller, M.D., of Hershey Medical Center) working with the department in developing emergency facilities," Dr. Bachman said. He estimates that $50 million will be needed for manpower and equipment for the delivery of emergency care over the next five years.

The secretary sees the state's health resources put to best use when delivering preventive and primary health care. He believes health maintenance organizations have a role as an alternate delivery system, but not as a panacea. The attention of doctors in the past has been directed toward acute and catastrophic care, he believes, and insurance plans were developed to help people pay for the cost of such care. Dr. Bachman envisions a redirection of resources—

including the talents and education of physicians themselves—toward the prevention of health problems.

The 49 year old professor of anesthesia at the University of Pennsylvania School of Medicine said he intends to call on the medical profession to help solve the problems in providing health care for all the people of the Commonwealth. "The medical profession is one of the greatest resources we have. Physicians are educated individuals steeped in the centuries' old tradition of service to mankind. We physicians must admit we have made some mistakes—in the future we must be concerned about nutrition, housing, pollution—all social problems—and we must lead in the effort to better conditions for all. I intend to approach physicians on these issues and to appeal to the instincts which led them into medicine to solicit their help in solving the problems that face us."

A graduate of the University of Maryland School of Medicine, Dr. Bachman took his residency training in Maryland and Massachusetts. He served as anesthesiologist at Johns Hopkins Hospital and as instructor of anesthesiology and of pharmacology and experimental therapeutics at the medical school there. He became director of anesthesiology at Children's Hospital of Philadelphia and joined the faculty of the University of Pennsylvania School of Medicine in 1955. Named professor of anesthesiology in 1966, he still holds that post, and remains consultant in anesthesia at the Veterans Administration Hospital in Philadelphia.

Dr. Bachman is a diplomate of the American Board of Anesthesiology and is an associate examiner for the board. He is a fellow of the American College of Anesthesiology, the American College of Chest Physicians, and the American Academy of Pediatrics.

Author of an impressive list of published scientific papers, the new secretary of health is a member of numerous professional organizations. He has served as president of both the Philadelphia and the Pennsylvania Societies of Anesthesiologists, and has been chairman of the American Academy of Pediatrics Section on Anesthesiology from 1970 to the present.

He has an active civic and political background, and was the Democratic candidate for Congress from Delaware County in 1964 and president of the Central Philadelphia Reform Democrats in 1968. Dr. Bachman and his wife, Sarah, have four children. They live in Philadelphia.

Delaware Valley Transplant Program organized

Transplant surgeons from six transplant hospitals in Philadelphia have recently organized a non-profit cooperative cadaver kidney procurement effort, the Delaware Valley Transplant Program. The program is sponsored by the Society of Transplant Surgeons and funded by the Greater Delaware Valley Regional Medical Program as part of a broad effort to improve medical services for patients with end stage renal disease. Surgeons, nephrologists, histocompatibility and preservation technicians at Albert Einstein Medical Center, Hahnemann Hospital, Lankenau Hospital, St. Christopher's Hospital, and the Hospital of the University of Pennsylvania all are contributing to the program. It is administered by the transplant coordinator, Donald W. Denny, M. S. W.

By dialing (215) KIDNEY-1, a physician anywhere in the three-state area can mobilize the organization. Program staff members are available *at all times* to respond to referrals with on-the-scene assistance in determining suitability of a potential donor, securing consent from relatives, and arranging for the approval of the medical examiner or coroner and donor hospital administration. After pronouncement of death by the attending physician, transplant surgeons are on call to perform the donor nephrectomy and place the kidneys on a portable preservation machine. Kidneys on such a machine can last up to fifty hours allowing for further assessment of their suitability for transplantation.

Costs incurred by donor hospitals are paid by one of the transplant centers, which is then reimbursed under the Social Security Act's 1972 amendments. Reimbursable costs include those incurred in determining brain death, assessing the function of the donor's kidneys, and surgically removing the kidneys. No charges are billed to the donor's family.

Physicians who are interested and would like more information should call Donald W. Denny.

At Officers' Conference

Harry Schwartz named first Donaldson memorial lecturer

Harry Schwartz, Ph. D., nationally known journalist and author of the book, *The Case for American Medicine,* will give the first Walter F. Donaldson memorial lecture at the State Society 1975 Officers' Conference in Harrisburg April 23 and 24. Dr. Schwartz is a member of the New York *Times* editorial board and a distinguished professor at the State University of New York, New Platz, New York.

Walter Foster Donaldson, M. D., (1873-1957) was an inspiration and guide to the Society for nearly half a century. Because he was loved and admired by so many members of PMS, a major portion of the 1975 Officers' Conference will be devoted to his memory. An accounting of Dr. Donaldson's leadership appears on this page.

Elliot L. Sagall, M. D., medical editor of *TRIAL* magazine, will speak on the American Society of Law and Medicine, Inc., formed in the spring of 1973. The society is a nonprofit, tax exempt organization whose major purpose is to promote continuing education in the area of legal medicine.

Dr. Sagall, a graduate of Harvard Medical School, is regional medical and rehabilitation consultant for the Insurance Company of North America and medicolegal consultant for plaintiff's counsels and major insurers in the New England area.

In recent years national health insurance has become a major issue in the United States. The Officers' Conference will feature key national political figures who will discuss the "Shape of National Health Insurance."

The conference will begin with greetings from R. William Alexander, M. D., chairman of the Officers' Conference Committee. A. Reynolds Crane, M. D., president, will then deliver the "State of the Society" address. James Sammons, M. D., executive vice president of the AMA, also is scheduled to address the conference.

The Pennsylvania Medical Political Action Committee will sponsor a presentation concerning state health legislation. Speakers from the state legislature and administration will participate.

Concurrent with the Officers' Conference will be a Speakers' Training Seminar which requires no tuition and will have an enrollment limited to thirty. It will begin at 8:30 a.m., April 23 and conclude after the 1:00 p.m. session the next day. Details are included on invitations sent by PMS.

The 1975 Officers' Conference will begin at 1:00 p.m. Wednesday, April 23 at the Host Inn, Harrisburg, and will conclude at 1:00 p.m. Thursday, April 24.

On June 26, 1957, the Pennsylvania Medical Society (then the Medical Society of the State of Pennsylvania) lost a rare mentor and friend, Walter Foster Donaldson, M. D. At the time of his death, Dr. Donaldson had served the Society in various capacities for forty-eight years.

Walter Foster Donaldson was born in Bridgeville, Allegheny County, September 13, 1873, to John Boyce and Elizabeth Foster Donaldson. He decided upon a medical career as his father and grandfather had done and received his medical degree from Northwestern University School of Medicine in 1898.

Dr. Donaldson became active in the Pennsylvania Medical Society in 1909 as chairman of the Committee on Criminal Malpractice until its dissolution in 1912. Five years later he was elected first vice president of the Society and succeeded to the presidency the next year at the death of Samuel G. Dixon, M. D.

At the 1918 annual session, Cyrus Lee Stevens, M. D., also owner and editor of the Pennsylvania Medical Journal, *retired as secretary to become president elect. The House of Delegates elected Dr. Donaldson permanent secretary. When he began his term, membership was 6,787 and the Society had assets of $35,278.35; in 1952, when he retired from office, membership was 10,284 and assets were $761,366.57. He was never too busy to aid the various Society committees or chairmen and he always took the time to indoctrinate a new county society secretary in his duties. He habitually visited the county societies and attended councilor district meetings throughout the state.*

Dr. Donaldson was elected editor of the Pennsylvania Medical Journal *and, from a scientific viewpoint, developed it into one of the nation's finest medical journals. He constantly presented wisdom and humor in his editorials and his column, "The Editor Ruminates." Dr. Donaldson maintained a strict advertising policy concerning questionable products but increased the advertising income from $14,012 in 1940 to $106,284 in 1957.*

In 1919 Dr. Donaldson had been appointed medical director of the Standard Life Insurance Company of America and was made president in 1946.

During the Society's centennial year, Dr. Donaldson urged publication of the History of the Society *and wrote a year by year history from 1896 to 1948 and a chapter on the "Publications of the Society."*

In addition to his activity in the State Society, Dr. Donaldson represented Pennsylvania at the American Medical Association House of Delegates from 1923 to 1948. He was a member of the Council on Medical Education and Hospitals from 1924 to 1931 and a member of the Judicial Council for twenty-five years.

Everyone who knew Dr. Donaldson admired and respected him throughout his life. He recognized the purpose of organized medicine when he wrote, "The members of The Medical Society of the State of Pennsylvania are federated to extend medical knowledge so that the profession shall become more useful to the public in prolonging and adding to the comfort of human life." He had also written that "Medical statesmanship comprises the art of changing the health condition of a community, county, or state from what it is to what it ought to be."

AMA files suit

HEW moves to implement planning act quickly

The National Health Planning and Resources Development Act passed by the Ninety-Third Congress on the final day of its session and signed by President Gerald Ford only a few hours before the final deadline has drawn quick action by the Department of Health, Education, and Welfare (HEW) and immediate attack from the AMA.

The legislation combines the functions of three existing health programs: Regional Medical Programs, Comprehensive Health Planning Agencies, and Hill Burton funding. It is seen as the means for providing review of federal spending under any national health insurance plan which might be enacted. The functions of these programs will be administered through agencies on the local, state, and federal levels. States will be required to enact certificate of need legislation.

Shortly after the presidential signing, the AMA announced it would file suit to have the law declared unconstitutional as an unwarranted assumption of state authority by the federal government. Meanwhile, HEW has moved quickly to implement the law. In a letter to all governors, HEW Secretary Caspar Weinberger asked for submission of Health Services Agency (HSA) area designations which would meet the law's requirements. He asked that these be submitted within 120 days. Under the law, HEW has until September 1, 1975 to establish boundaries for these areas. In Pennsylvania strong pressure is expected to support having these HSA boundaries conform with those of the nine existing Comprehensive Health Planning B Agencies.

Health Services Agencies will be appointed in the areas, supervised by governing boards which by law will include a minority of health care providers. HSAs will implement both long and short range health plans for the areas under national guidelines developed by HEW. The law gives HSAs strong power to enforce their planning decisions for health care institutions. They will exercise control over the use of federal funds for the health care field in their areas.

The law establishes a National Council on Health Planning and Development within HEW and two state level agencies—one for state health planning and development and one for statewide health coordinating.

The law directs the secretary of HEW to implement a uniform accounting system for health services institutions within one year. It directs the establishment of a uniform system of calculating rates to be charged by health insurers and the development of a classification system for health services institutions.

FMG seminar planned

A review seminar for foreign medical graduates will be offered by Hahnemann Medical College and Hospital June 16 to July 31. The course, primarily in internal medicine, will be held over a total of thirty days, seven hours of instruction per day.

For further information, contact the program director, Krishan Bharadwaja, M. D., or Robert J. Schaefer, director of continuing education, Hahnemann Medical College, 230 N. Broad Street, Philadelphia, Pa. 19102. Telephone: (215) 448-8264.

Malpractice study funded

The American Arbitration Association has received a two-year grant provided equally by the Henry J. Kaiser Family Foundation and the Commonwealth fund for a study of medical malpractice dispute settlement systems now in use and of ways to preserve the economic rights of doctors, health organizations, and patients. The project will be administered by the AAA Research Institute under the general direction of Donald B. Straus, president. "While no one wishes to see a patient deprived of proper compensation, the present system seems to be overly rewarding to a few at the expense of the majority," said Mr. Straus. "Even those few who collect large awards are victimized by a system which contributes nothing to the quality of medical care. . . . Our research will seek alternative methods for resolving claims of faulty medical care that are compatible both with good medicine and equal justice."

Irving Ladimer, M. D., will direct the project's professional team which will review and analyze medical malpractice experience of medical groups, health maintenance organizations, medical care foundations and other agencies which provide medical services to members or subscribers on a regular basis.

The Institute's survey will concern the handling of patient's complaints about medical service and alleged injury; the project staff will seek solutions to the growing malpractice crisis. The AAA will then recommend methods of better communication and settlement through mediation and arbitration.

Allegheny, Philadelphia leaders installed

County medical societies name new officers

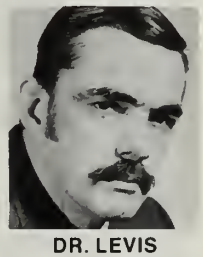
The Philadelphia County Medical Society installed new officers January 15. James B. Donaldson, M. D., professor of medicine at Temple University School of Medicine, is the new president. President elect is Milton Perloff, M. D., of Albert Einstein Medical Center. Charles Shuman, M. D., professor of medicine at Temple, is vice president. Edward Resnick, M. D., professor of orthopedics at Temple, and David Cristol, M. D., of Albert Einstein Medical Center, are secretary and treasurer.

Dr. Donaldson, born in Clydebank, Scotland, moved to this country at the age of seven and became a naturalized citizen in 1930. He received his medical degree from Temple in 1944, served in the Navy from 1946 to 1948, and while on duty was chief of medicine at the U. S. Naval Hospital, Guantanamo Bay, Cuba.

Certified by the American Board of Internal Medicine in 1952, he became an assistant professor of medicine at Hahnemann Medical College. He was appointed acting chairman of the department of medicine in 1958.

The next year Dr. Donaldson became professor of clinical medicine at Temple University Medical School.

DR. DONALDSON



DR. LEVIS

Dr. Donaldson is a fellow of the American College of Physicians, College of Physicians of Philadelphia, and American College of Cardiology, and a diplomate of the Pan American Medical Association.

The Allegheny County Medical Society held its annual dinner dance January 18. The affair marked the society's 110th anniversary. Among the activities were the installation of the new officers and an official greeting from the president of the American Medical Association, Malcolm C. Todd, M. D.

Michael P. Levis, M. D., Pittsburgh, became president of the society during the installation. Lawrence D. Ellis, M.D., Pittsburgh, is president elect and first vice president is A. Linn Weigel, M. D., Pittsburgh. Secretary and treasurer are Joseph V. Caliguiri, M. D., Coraopolis, and Robert M. Laughlin, M. D., Pittsburgh.

David W. Clare, M. D., Pittsburgh, retiring president of the society, received the President's Plaque. Twenty society members received the Pennsylvania Medical Society awards for fifty years in medical practice.

Practice management seminar planned for May

The PMS Council on Education and Science is presenting a third practice management seminar Friday, May 2 and Saturday morning, May 3 at the Penn Harris Motor Inn, Harrisburg. At the seminar, experts will discuss the business aspects of medical practice in an attempt to assist the physician in improving either individual or group practice.

Leif C. Beck, LI.B., president of Management Consulting for Professionals, Inc., Bala Cynwyd, will head the faculty. He is a member of the Society of Professional Business Consultants, author of a monthly management series in PENNSYLVANIA MEDICINE, editorial consultant for *Medical Economics*, and an expert on management, taxation, and professional corporations.

Another faculty member is Roger Harrison, C. P. B. C., owner of Roger Harrison Associates, Inc., Norman, Oklahoma. He is past president and chairman of the board of examiners of the Society of Professional Business Consultants, and editorial consultant for *Medical Economics*. Mr. Harrison has had 17 years' experience as a business consultant solely to physicians. Also on the faculty is Thomas E. Zirkle, C. P. B. C., owner of Professional Management Associates, Inc., Chicago, Illinois, and Denver, Colorado, and past president of the Society of Professional Business Consultants. He is also contributing author to *Prism*, author of the book, *Corporate Practice,* and a lecturer on practising law programs.

Among the topics for discussion are office facilities and equipment, personnel and medical administration, fees and fee control, billing and collecting systems, bookkeeping and accounting requirements, group practice matters, and management of professional corporations.

Further information and registration forms may be obtained from the Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, Pa. 17043. Telephone (717) 238-1635.

Political action success depends on support says chairman

The Pennsylvania Medical Political Action Committee, with a healthy record of political success in the 1974 general elections, needs more contributing and sustaining members if it is to continue to succeed. PaMPAC contributed $81,000 to ninety-one candidates of both parties in the general elections of 1974. Of the ninety-one candidates considered friends of medicine eighty-one were victorious.

With the general election of candidates for 1974 past, attention now centers on issues vital to physicians. Most important are increasing government regulations, the state of the national economy, the malpractice crisis, the freedom to practice medicine. In light of these serious issues, a view to the elections of 1976 is not premature.

R. William Alexander, M. D., chairman of the Board of Directors of the Pennsylvania Medical Political Action Committee, shares some urgent thoughts on the need for continued support for PaMPAC.

Dr. Alexander, could you briefly describe the program of PaMPAC?

Your Pennsylvania Medical Political Action Committee is a method by which you can support candidates of your choice, friendly to medicine, in both the national and state legislatures regardless of party affiliations. Your dollars are spent where *you* direct them to be spent.

In light of recent political scandal, how do you view political action today?

Recently, political action committees have developed an unsavory connotation. They have been accused of buying congressmen, senators, and presidents. Until *all* campaigns are federally and state funded, the facts and the law remain that contributions—properly given to candidates—are morally and legally correct.

Why should physicians actively support any candidate?

If we do not carefully select our candidates before the primary election, then whom do we have to blame for a poor candidate in the general election?

Why do we hear so many well-educated and influential individuals complain that none of the candidates is a satisfactory choice and they won't vote for any of them? Who is really to blame? Each of us.

How do you determine which candidate to endorse?

The degree of local physician support for a candidate determines PaMPAC's choice. While other political action committees dictate from their national headquarters, and funds are controlled by a few leaders, PaMPAC relies on the local physicians to direct campaign spending.

Where does the candidate support money come from?

PaMPAC accumulates its candidates support fund slowly and painfully in the amounts of $35 for regular membership or $100 for sustaining membership for physicians.

Is all the money spent on candidate support?

No. The rest of PaMPAC's dollars is spent in physician education campaign material and organization management.

Finally, Dr. Alexander, now that the general elections of 1974 are over, what do you forecast for 1975 and the upcoming election of 1976?

We feel that special interest groups, which include PaMPAC-AMPAC, will play a more important role in candidate support in future elections, especially since election reform legislation has recently been enacted by the Congress of the United States limiting campaign spending. Instead of candidates receiving large sums from individuals, they will now rely on political action committees that are legally set up within the reform system.

Has PaMPAC responded to this reliance on political action groups?

Yes. PaMPAC is promoting a sustaining membership drive ($100 membership) among members of the Board of Trustees, the Council on Governmental Relations, and the AMA delegation. Sustaining members are the backbone of the medical political action movement. Furthermore, the PaMPAC Board of Directors recently amended its bylaws to require that each of its board members shall be a sustaining member of PaMPAC-AMPAC. I feel that this type of endorsement points out the importance of political activity within organized medicine.

AMA resolutions support local utilization review

MATTHEW MARSHALL, JR., M.D.
Pittsburgh

The actions of the House of Delegates of the American Medical Association in approving resolutions introduced by the Pennsylvania Delegation after approval by the PMS House of Delegates should have a beneficial impact on medical practice. AMA policy now will be directed to reducing the time and unnecessary paper work of medical audit and utilization review activities and encouraging elimination of multiple accreditation procedures.

The extent to which physicians recognized that some methods proposed to assure the quality of care have not demonstrated any validity, reliability, or cost effectiveness was not fully apparent until the unanimous approval of this part of the resolution by the AMA House of Delegates. The resolve clearly establishes policy to the effect that local organizations of practicing physicians (Pennsylvania PSROs organized by practicing physicians) rather than the Joint Commission on Accreditation of Hospitals should be the agency primarily responsible for determining that medical staff audit and utilization review procedures are adequate. This is timely. It was opposed by only a few delegates closely identified with JCAH.

There was a time when assurance of quality was assumed by the autocracy of medicine. It was appropriate when there were but a few revered giants of medicine in each field, and local medical organizations had neither the professional expertise, staff, or funds to assume this responsibility. Times have changed and the AMA has made it clear that peer review rather than elite review is the order of the day.

JCAH standards questioned

Part of this problem lies with the standards of the Joint Commission on Accreditation of Hospitals which state, "that hospital accreditation depends upon evidence that the medical staff is effectively imple-

Resolution 24 - Medical Audit and Review Procedures

Whereas, A profusion of methodologies are currently advocated as appropriate for medical staffs to assure quality of care; and

Whereas, There is a definite need to assure that methods of review are of appropriate quality, effectiveness, and reasonable cost, relative to the medical care being evaluated, since the time needed for medical audit and utilization review may reduce the time and personnel available for actual patient care; and

Whereas, There is little use in devising or promoting elaborate time-consuming protocols for medical staffs to devise criteria or medical audit studies if the medical facts upon which the system is based cannot be readily or accurately determined, if the need for medical audit is unlikely or there is no plan for the utilization of the information collected; and

Whereas, Techniques for screening, abstracting, and preparing many items of medical review remain in the experimental stage; and

Whereas, There is need to assure that the underlying valid principles of peer review will not be erased by an avalanche of bureaucratic requirements whether developed by governmental bureaucracy or by voluntary agencies to protect physicians; and

Whereas, Responsibility for quality of care should be developed primarily at the local level; and

Whereas, The current "crisis atmosphere" to assure quality of care could lead to regulatory methods that could create an overkill environment less conducive to quality of care; therefore be it

Resolved, **That the competence of the physician, practicing in an environment conducive to his ability to make judgments and exercise his skills in the best interests of his patients, be recognized as the prime assurance to the public of quality care; and be it further**

Resolved, **That medical audit or utilization protocols which hospital medical staffs are *required* to use for either concurrent or retrospective review for either PSRO, Joint Commission on Accreditation, Medicare, Medicaid and others, approval be confined to those methods whose screening techniques can be reasonably expected to be valid, reliable and respectful of the necessity to use both physicians and other personnel involved in a cost effective manner; and be it further**

Resolved, **That when such screening techniques show that the medical care in the particular category under review is consistent with the general standard of care for the region, no further professional review should be *required*; and be it further**

Resolved, **That to avoid duplication, when a peer review organization, organized by the practicing physicians of the area, has determined that a medical staff has an adequate medical audit and utilization procedure, it should be accepted by the state agency, the Joint Commission on Accreditation, Medicare, Medicaid and others, unless there is evidence by the state agency or the Joint Commission that the peer review organization has not acted in the best interest of quality medical care; and be it further**

Resolved, **That the American Medical Association develop appropriate standards or protocols for evaluating the effectiveness and efficiency of present and proposed medical care review processes.**

menting direct measures leading to assurance of quality of care." Although quality of care was not defined, ambiguity is preserved as it goes on to state, "there must be continuing medical education shaped primarily on the manifested need of providing optimum quality of care". That, too, is undefined and without evidence that continuing medical education within a hospital is indeed invariably the optimum or even invariably a necessary site for that activity. Finally it states that "there shall be retrospective review and evaluation of the pattern and quality of clinical practice through patient care audit" even though the charts may be completed long after discharge in some approved hospitals without requiring a system of data collection that has been shown to be reasonably valid, reliable, or cost effective.

JCAH methodology requires a medical staff committee to set the criteria for medical care without any requirements that they be based on scientific principles. Next, the physicians, without any experience in data retrieval, are expected to give instructions to a committee assistant without any guidelines for this process. Is it any wonder that this gives full rein for some physicians so inclined, to request massive amounts of information of questionable reliability without any clear idea as to what is to be done with it other than filing lengthy reports on patients long gone? Or, is it any wonder that the reports show, with all the hindsight of a Monday morning quarterback, that some detail of each case could be handled better?

Physician provides quality

Indeed the need to recognize that quality of care depends primarily upon a physician practicing in an environment conducive to his ability to make judgments in the best interests of his patients appears to be somewhat overlooked. The promotion of that atmosphere must be the most essential ingredient in any quality assurance program. For example, does leaving the office at 4 P.M. and putting off patients to go to a meeting to arbitrarily develop criteria for kinds of care he does not render, or respond to questions as to why his pattern does not correspond to criteria developed by other physicians unfamiliar with his type of practice contribute to the quality of care? Does it merely detract from his time and willingness to accept responsibility for medical staff functions that can be shown to be necessary?

Screening methods should not create the need for medical audit committees to do more work. For example, in an experimental study, one rural hospital showed that 80 percent of the appendices removed demonstrated acute appendicitis and most patients were discharged within the range of the PMS criteria. Under the circumstances, it would seem a waste of time to require or teach that medical staff how to do medical audit by establishing criteria and studying the outcome of acute appendicitis. In contrast to this, a recent study designed by non-urologists, sets a standard that there should be a urine culture showing no growth upon discharge after TUR, with the exception that if a culture and sensitivities are done and appropriate antibiotic prescribed. This criteria was set despite the many documented studies which show an eventual sterile urine is most dependent upon the completeness of the transurethral resection. When such a criteria is combined with a criteria of twelve days for an uncomplicated TUR, it merely acts to increase health care costs by encouraging the unnecessary use of antibiotics, increasing the length of stay, and consuming professional and non-professional time unproductively.

Dr. Marshall is a member of the Pennsylvania Delegation to the AMA House of Delegates and president of the Pennsylvania Medical Care Foundation.

Our experience leads us to believe that quality, care cannot be defined. Indeed, it is only subprofessional care that can be defined in only the broadest quasi precise fashion. We have seen that methods of selection of criteria and the design of studies are fraught with difficulties and that the possibility of misinterpretation of data is real.

PSRO and JCAH require that medical audit activities be carried out. If so, it is essential that physicians' time be conserved to those activities that can be demonstrated to be productive, and hospital costs must not be increased merely to satisfy dogmatic requirements.

Dr. Porterfield has stated that the joint commission's goal is quality through professional self-discipline. It is hoped the JCAH will review the resolution passed by the American Medical Association and will develop a program that will coordinate with the Pennsylvania Medical Care Foundation and other statewide support centers in assisting the PSROs when organized by local practicing physicians in meeting the challenge of making medical audit worth the time and effort required.

In summary it must be stated that: 1. PSRO regulations do **not** require that medical staffs comply with the JCAH medical audit procedures; and 2. The policy of the AMA and of the State Society states that when a medical staff's medical audit procedures meet PSRO requirements, the JCAH should accept that approval as meeting JCAH standards for quality appraisal.

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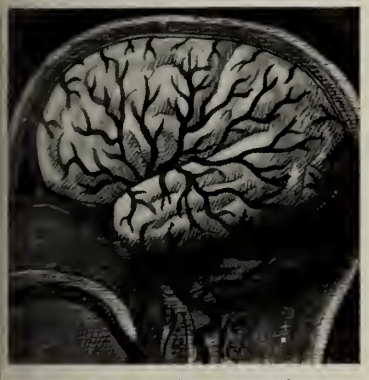

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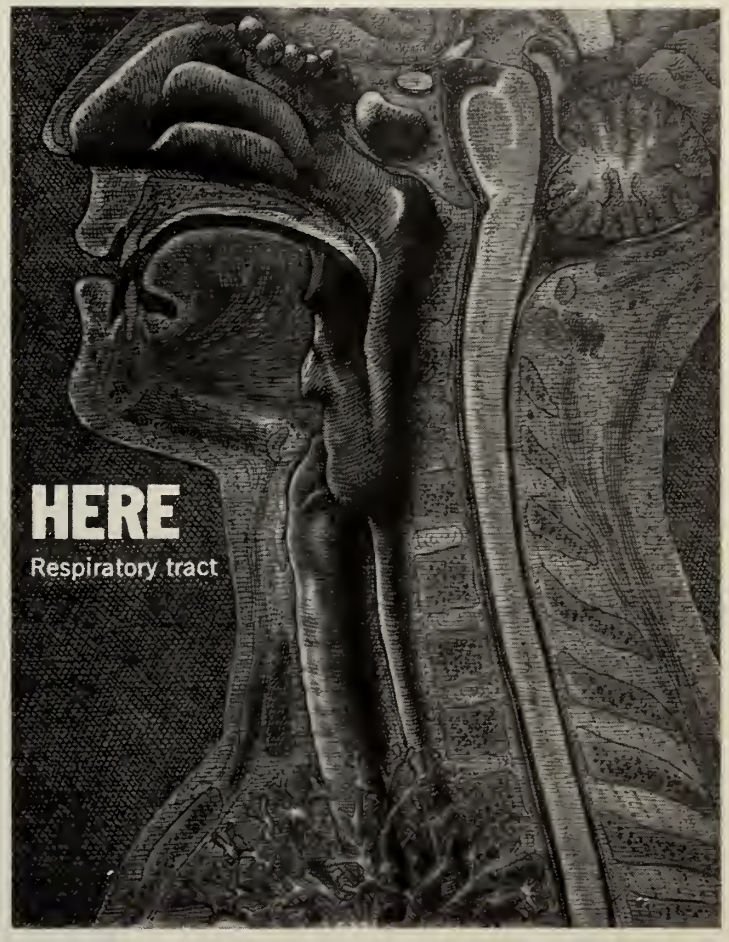

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The Role of the Detail Man

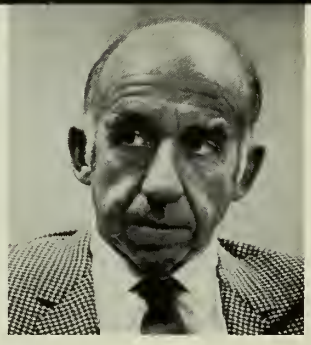
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.,* the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

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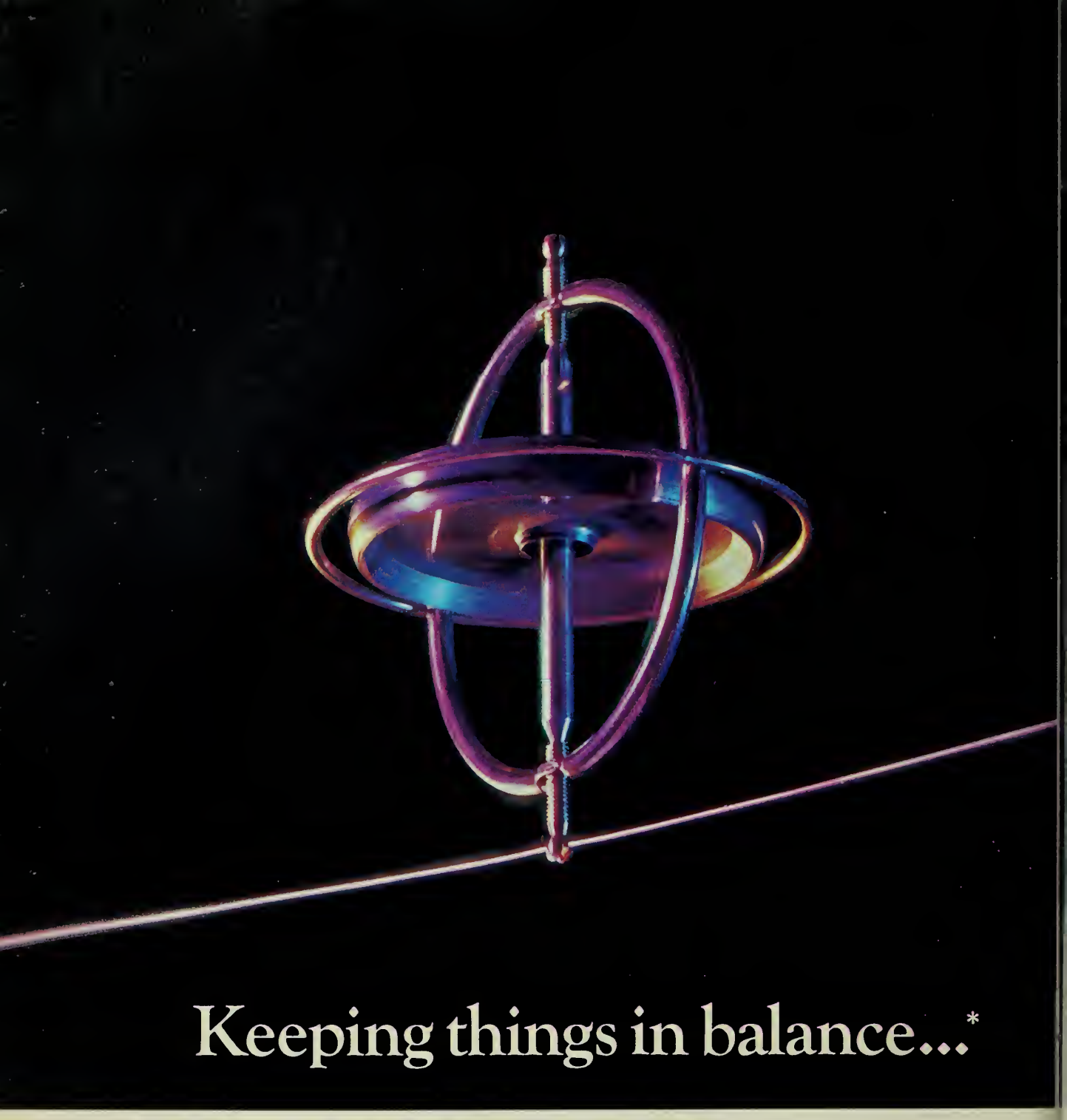

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Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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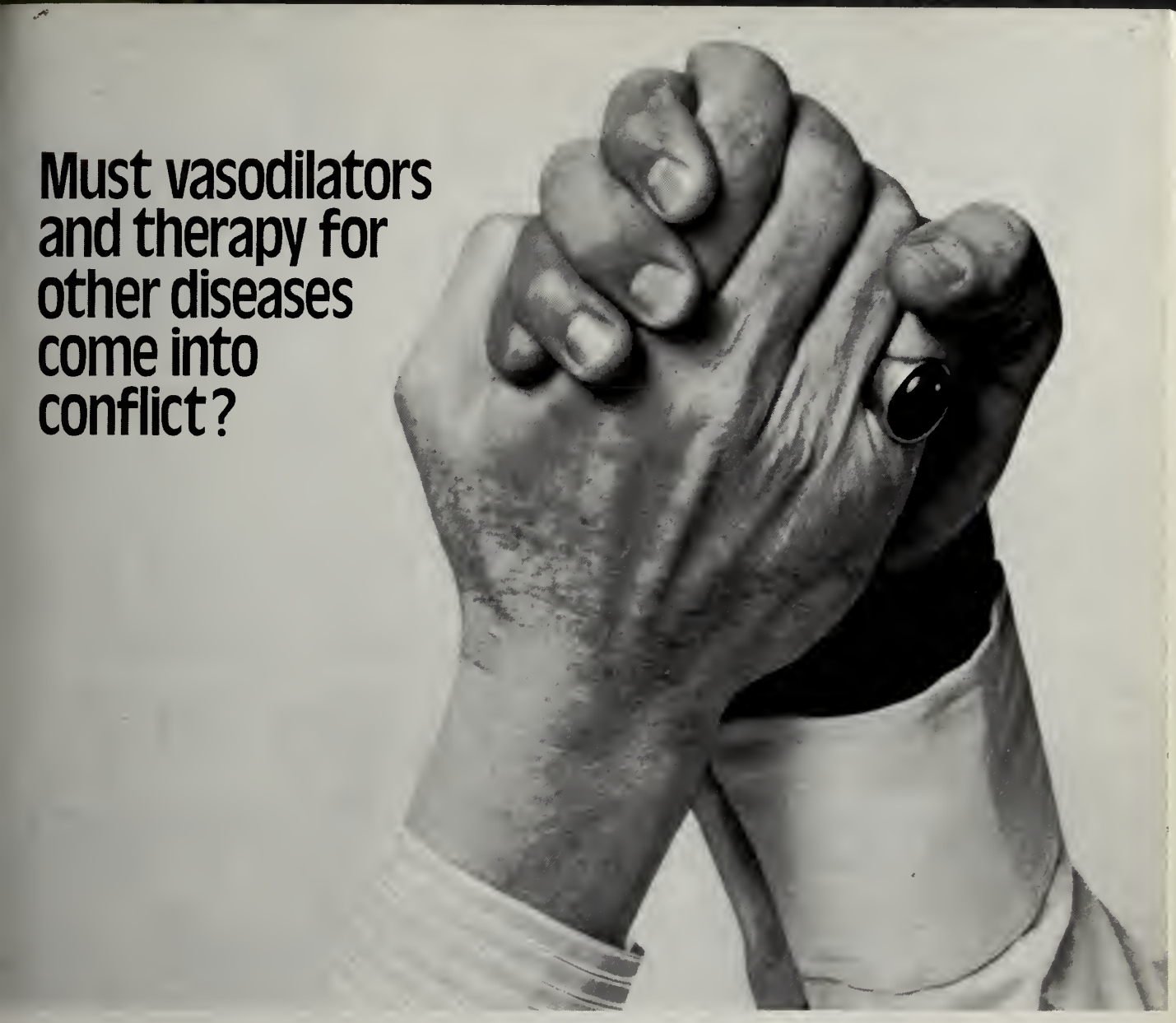
Must vasodilators and therapy for other diseases come into conflict?



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(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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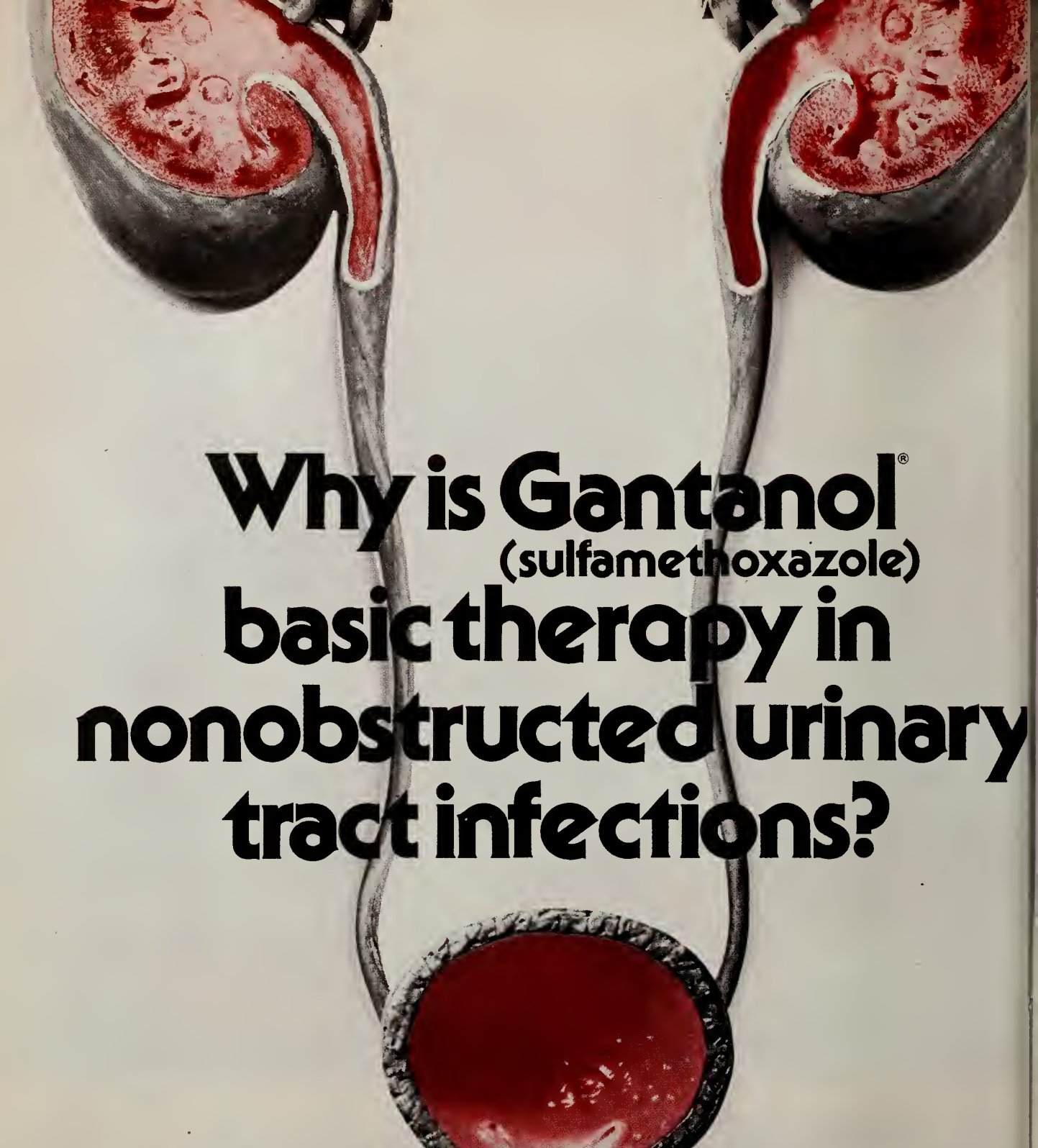
Mead Johnson LABORATORIES



Why is Gantanol® (sulfamethoxazole) basic therapy in nonobstructed urinary tract infections?

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or pr vent sequelae (rheumatic fever, glomerulonephriti of such infections. Deaths from hypersensitivity rea tions, agranulocytosis, aplastic anemia and other bloc dyscrasias have been reported and early clinical signs (so throat, fever, pallor, purpura or jaundice) may indicate seriou blood disorders. Frequent CBC and urinalysis with microscop examination are recommended during sulfonamide therapy. Insuf cient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal hepatic function, severe allergy, bronchial asthma; in glucose-6 phosphate dehydrogenase-deficient individuals in whom dose related hemolysis may occur. Maintain adequate fluid intake prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplas tic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pu

Because it is considered a good choice...

- for efficacy in nonobstructed cystitis, pyelonephritis and pyelitis
- for control of susceptible *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*
- for prompt antibacterial blood and urine levels in from 2 to 3 hours after initial 2-gram adult dose
- for economical around-the-clock coverage
- for maximum patient cooperation with easy-to-remember B.I.D. dosage

Basic Therapy

Gantanol®

(sulfamethoxazole)

Tablets/Suspension (0.5 Gm) (0.5 Gm/teasp.)

...pura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

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Nutley, N.J. 07110

MDs in the news

ROBERT COHEN, M. D., center, has received the 1974 Moses Award for excellence in clinical teaching. Presenting the award were, left to right, Roger Sevy, M. D., Dean of Temple University School of Medicine; and Mrs. Russell P. Moses, for whose late husband the award is named. On Dr. Cohen's right are Alan Marks, M. D., and Howard Warner, M. D., who joined in the presentation.

Paul L. Carmichael, M.D., Philadelphia, has been appointed associate professor in the department of radiation therapy and nuclear medicine at Hahnemann Medical College and Hospital. He is also an associate surgeon at Wills Eye Hospital.

Lester Cramer, M. D., professor of surgery and chief of plastic surgery at Temple University Health Sciences Center, has been elected president of the Educational Foundation of the American Society of Plastic and Reconstructive Surgery. Dr. Cramer received his medical degree in 1953 from Columbia University College of Physicians and Surgeons. He served on the staff at the University of Rochester School of Medicine and Strong Memorial Hospital, Rochester, until he joined the faculty at Temple University School of Medicine in 1966.

Michael T. Donahoe, M. D., and John Wilson, M. D., both of Chambersburg, have successfully passed their board examinations and have been certified as diplomates in internal medicine by the American Board of Internal Medicine.

Milton J. Freiwald, M. D., Philadelphia, has been appointed medical advisor for Region III of the Department of Health, Education, and Welfare. In this capacity Dr. Freiwald will head the medical consultant staff and be responsible for overseeing the medical program in the region to assure uniformity of medical policies and procedures. Dr. Freiwald is a member of the attending staff of Albert Einstein Medical Center of Philadelphia, Northern Division.

Millard N. Croll, M.D., professor of radiation therapy and nuclear medicine, Hahnemann Medical College and Hospital, presented a paper at the First World Congress of Nuclear Medicine, held recently in Tokyo. The paper was entitled "Clinical Evaluation of a Computerized Multicrystal Imaging System." He also chaired a session of the congress on computers.

Henry Ellwood Helling, M. D., recently celebrated his 92nd birthday at a dinner held at the Ellwood City Hospital. Dr. Helling had retired after 65 years of medical practice.

Daniel P. Greenlee, M. D., Waynesburg, was recently honored by the Pennsylvania Medical Society for having completed fifty years of medical service.

Albrecht W. Schmitt, M. D., clinical associate professor in the department of obstetrics and gynecology at the Medical College of Pennsylvania, recently presented two scientific papers on DES to medical groups. One paper was presented at a three-day symposium at the Wilmington Medical Center and the other for the Obstetrical Society of Philadelphia. Dr. Schmitt is president of the American Society for Colposcopy and Colpomicroscopy. He is a diplomate of the American Board of Obstetrics and Gynecology and a fellow of the American College of Obstetricians and Gynecologists.

Among those inducted recently into the fellowship of the American College of Surgeons was **Houshang Vossoughi, M. D.,** Arnold. Dr. Vossoughi, an orthopedic surgeon, is a native of Tehran, Iran, and a graduate of the Tehran Medical School. He served his residency in orthopedic surgery in Allegheny General Hospital, Pittsburgh. He is certified by the American Board of Orthopedic Surgery and is on the staff of Allegheny Valley Hospital, Nastrona Heights, and Citizens General Hospital, New Kensington.

William M. Cooper, M. D., has been appointed to the newly created posts of associate dean for Continuing Medical Education in the University of Pittsburgh School of Medicine and director of continuing education of the University Health Center of Pittsburgh. Dr. Cooper will assume responsibility for the consolidation and coordination of all continuing education activities in Pitt's schools of the health professions. He is currently a member of the medical staffs of Presbyterian-University Hospital, Shadyside Hospital, Western Pennsylvania Hospital, and Magee-Womens Hospital.

Joseph T. Marconis, M. D., Pottsville, was elected President of the Pennsylvania Urological Association at its recent annual meeting. Dr. Marconis received his medical degree from Hahnemann Medical College. He is certified by the American Board of Urology. Dr. Marconis is also a fellow of the American and International Colleges of Surgeons.

Cedric C. Jimerson, M. D., chief of surgery at Reading Community General Hospital, recently was elected president of the Eastern Chapter, American College of Surgeons. Dr. Jimerson was named head of the professional association during its annual meeting in Allentown.

Theodore L. Donmoyer, M. D., Allentown, a specialist in cardiovascular diseases, was among eighty-nine United States and Canadian physicians recently admitted to the American College of Cardiology.

Jay A. Wenger, M. D., has been appointed assistant professor in the department of radiation therapy and nuclear medicine, Hahnemann Medical College and Hospital. Dr. Wenger is director of the department of radiology at Grandview Hospital, Sellersville.

Douglas E. Trent, M. D., New Brighton, was installed as a fellow of the American College of Surgeons recently at Miami Beach, Florida. Dr. Trent is on the surgical staff of the Medical Center of Beaver County.

Residents of the Herminie area recently honored **Andrew J. Cerne, M. D.,** with a testimonial dinner and informal reception. Dr. Cerne has served the community for 25 years.

A testimonial dinner was held recently for **Harry Lubow, M. D.,** of Irwin. The dinner was sponsored by friends in the Irwin area where Dr. Lubow has served as a general practitioner for 40 years.

Johann Koenig, M. D., Hazleton, passed the radioisotopic pathology examination given recently by the American Board of Pathology. Dr. Koenig is pathologist in St. Joseph Hospital and is presently chief of the medical staff at the Hazleton State General Hospital. He is a diplomate and fellow of the American Society of Clinical Pathologists and of the College of American Pathologists.

Takashi Honda, M. D., associate professor of radiation therapy and nuclear medicine, Hahnemann Medical College and Hospital, chaired a session on radiopharmaceuticals at the First World Congress of Nuclear Medicine, held in Tokyo.

Thomas G. McLellan, Jr., M. D., Connellsville, an ophthalmologist, recently was named a fellow of the Philadelphia College of Physicians. Dr. McLellan was honored at a dinner commemorating the 100th anniversary of the founding of the department of opthalmology at the University of Pennsylvania.

New Officers

Adams County Medical Society

Paul Pifer, M. D., Gettysburg, President
Edward Baranski, M. D., Gettysburg, president elect
Joseph Alcaro, M. D., Gettysburg, secretary treasurer

Cambria County Medical Society

Thomas Schaefer, M. D., Johnstown, president
William Palmer, M. D., Ligonier, president elect
Robert Mrkich, M. D., Portage, vice president
George Ashman, M. D., Johnstown, secretary
William Hughes, M. D., Johnstown, treasurer

Jefferson County Medical Society

W. G. Lundgren, M. D., Du Bois, president
R. B. Haglund, M. D., Du Bois, secretary treasurer

Lancaster City and County Medical Society

Roland A. Loeb, M. D., Lancaster, president
James F. Young, M. D., Lancaster, first vice president
John L. Farmer, M. D., Lancaster, second vice president
F. Barrie Moberg, M. D., Lancaster, secretary treasurer

Lackawana County Medical Society

Edward J. Notari, M. D., Dunmore, president
Dominick A. Cruciani, Jr., M. D., Scranton, president elect
Stanley W. Boland, M. D., Clarks Summit, first vice president
Charles J. Bannon, M. D., Scranton, second vice president
Edwin C. Neville, M. D., Scranton, secretary treasurer

Bedford County Medical Society

John E. Hartle, M. D., Everett, president
Victor Maffucci, Jr., M. D., Bedford, president elect
Philip C. Grana, M. D., Bedford, secretary treasurer

Berks County Medical Society

John M. Kearney, M. D., Jacksonwald, president
Eugene Mendelsohn, M. D., Reading, president elect
James F. Welsh, M. D., Reading, secretary treasurer

Mercer County Medical Society

Vincent Ricciutti, M. D., Sharon, president
William McWhirter, M. D., Greenville, president elect
Theodore Yarboro, M. D., Sharon, vice president
Robert Allen, M. D., Sharon, secretary treasurer

cardiovascular brief

NUTRITION

Determination of the lipid profile, and particularly serum cholesterol, should be made part of all health-maintenance examinations for both men and women beginning in early adult life.

Since dietary modifications do influence serum cholesterol and triglycerides, they must be considered important preventive and therapeutic measures. Moreover, it is possible to plan changes in diet which are palatable, effective, economically feasible, nutritionally sound, and applicable throughout most of life ..... excerpt from DIET AND CORONARY HEART DISEASE, American Heart Association.

The Heart Association offers the physician information for nutrition counseling, including sample patient diets and meal-planning materials.

MATERIALS FOR PHYSICIANS:

( ) *A Maximal Approach to the Dietary Treatment of the Hyperlipidemias.* Series of individual patient diets, including *The Physician's Handbook; Diet A:* Low Cholesterol (100 mg), Moderately Low Fat Diet; *Diet B:* Low Cholesterol (200 mg), Moderately Low Fat Diet; *Diet C:* The Low Cholesterol Polyunsaturated Fat Diet; *Diet D:* Extremely Low Fat Diet. ($3.59 for complete series.)

( ) *Physician's Guide to Hyperlipidemia.* Donald S. Frederickson, M. D. (Free sample copy)

( ) *Use of Diet Therapy in Hyperlipidemia.* Wall Chart analyzing different diets. (Free sample copy)

( ) *Hyperlipidemia and Coronary Artery Disease - A Practical Approach.* Clinical Practice of Cardiology Series; audio-visual lecture. Frank R. Smith, M. D.; Paul H. Schreibman, M. D. ($7)

( ) *Diet and Coronary Artery Disease.* Statement of AHA Committee on Nutrition. (Free sample copy)

( ) *The Pediatrician and Atherosclerosis.* Reprint: February 1972 issue of "Pediatrics." (Free sample copy)

( ) *Guidelines for Professional Personnel in Use of Programmed Instruction for Fat-Controlled Diet, 1800 Calories.* (Free sample copy)

( ) *Nutrition/Cardiovascular Reviews, 1970-71, 1972.* Annotated bibliography of articles on nutrition as it relates to cardiovascular disease. ( ) 1970-71 (85c), ( ) 1972 ($1.10)

( ) *A Controlled Clinical Trial of a Diet High in Unsaturated Fat.* AHA Monograph Series #25 ($4)

( ) *Mass Field Trials of the Diet-Heart Question.* AHA Monograph Series #28 ($4)

FOR YOUR PATIENTS:

Free sample copies are available:

( ) Eat Well But Eat Wisely
( ) The Way to a Man's Heart
( ) Recipes for Fat-controlled, Low Cholesterol Meals
( ) Save Food $ and Help Your Heart
( ) Healthy Eating for Teenagers
( ) Planning Fat-controlled Meals for 1200-1800 Calories
( ) Planning Fat-controlled Meals for Approximately 2000-2600 Calories
( ) Programmed Instruction for Fat-controlled Diet, 1800 Calories
( ) Your 500 Milligram Sodium Diet
( ) Your 1000 Milligram Sodium Diet
( ) Your Mild Sodium-restricted Diet
( ) Information about the "American Heart Association Cookbook"

Free samples of most of the above materials are available but please note some of the special professional items are offered at cost; these items will be distributed through local Chapters which will bill you. Copies of any of these materials may be obtained through your local Heart Chapter, or from:

AMERICAN HEART ASSOCIATION, PENNSYLVANIA AFFILIATE
P. O. Box 2435, Harrisburg, Pennsylvania 17105

NAME (Please print) _____

ADDRESS _____ ZIP _____

REPORT OF CONTINUING MEDICAL EDUCATION (continued)

Sponsor: Institution, or Publication, or Physician, or Self	Location City	Location State	Description of Learning Activity (Course, paper, journal, self-assessment prgm., etc.)	Dates of Attendance (inclusive)	Hours of Study	TOTALS
Brought Forward from Previous Page: Total number of hours spent in Category 1 activities:						
CATEGORY 2: C.M.E. Activities with Non-accredited Sponsorship (There is a limit of 45 credit hours here.)						
Total number of hours spent in Category 2 activities:						
CATEGORY 3: Medical Teaching (There is a limit of 45 credit hours for this category.)						
Total number of hours spent in Category 3 activities:						
CATEGORY 4: Papers, Publications, Books and Exhibits (There is a 40 credit hour limit for this category.)						
Total number of hours spent in Category 4 activities:						
CATEGORY 5: Non-supervised Individual C.M.E. Activities (There is a limit of 45 credit hours for this category. Not more than 22 credit hours may be claimed in any one subcategory.)						
Total number of hours spent in Category 5 activities:						
CATEGORY 6: Other Meritorious Learning Experiences (There is a 45 credit hour limit. Attach description) Total number of hours spent in Category 6 activities:						

TOTAL CREDIT HOURS - Completed During the Three Year Qualifying Period Immediately Preceding _____

Name and Address: _____

Medical Education Number: _____ (from Membership card)

Signature: _____

Report of Continuing Medical Education for AMA's Physician's Recognition Award

List below all hours in which you participated in any type of continuing medical education activity.

Sponsor: Institution	Location City State	Description of Learning Activity (Course, seminar, c.m.e. intermittent program, etc.)	Dates of Attendance (inclusive)	Hours of Study	TOTALS

CATEGORY 1: C.M.E. Activities with Accredited Sponsorship (At least 60 credit hours are required. The total — 150 credit hours — may be earned in this category.)

Please check if you have:

☐ California Medical Association c.m.e. Certificate
☐ Oregon Medical Association c.m.e. Certificate
☐ Arizona Medical Association c.m.e. Certificate
☐ A.A.F.P. Membership in Good Standing (no other data is required)

Total number of hours spent in Category 1 activities (carry forward to next page): _____

Continuing medical education... now a PMS membership requirement

NEW REPORT FORMS NOW AVAILABLE!

Here it is!

The AMA has agreed to accept PMS designed forms as an official application for the PHYSICIAN'S RECOGNITION AWARD

"Rule bending" includes:

1. You may report your c.m.e. activities just as soon as you have 150 hours total with 60 hours minimum in Category 1 . . . disregard yearly PRA schedule.
2. You may report all c.m.e. activities for three years prior to the date of your application . . . forget the former cut-off date of June 30.
3. Forms allow more space for Category 1 listings and easy addition of hours.
4. You will receive an acknowledgement from AMA indicating when you can expect to receive the actual PRA certificate.

For example:

1. On March 10, 1975 you have accumulated more than 150 hours of continuing medical education hours. Report it immediately to the AMA.
2. Your report may include all time accumulated in the period March 10, 1975 back to March 10, 1972.

Tear out the form on the opposite page.
Complete it, attach your check in the amount of $5 for members ($10 for non-members of AMA). Make check payable to: American Medical Association
Sign the report form and mail to: Department of Continuing Medical Education, AMA
535 North Dearborn Street, Chicago, Ill. 60610

For application forms or additional information, contact:
Council on Education and Science
Pennsylvania Medical Society
20 Erford Road
Lemoyne, Pa. 17043
Telephone (717) 238-1635

editorials

American Drug Lag—financial, therapeutic dilemma

The rate at which drugs become available for use on the world market differs greatly from country to country. Because of differences in the method of drug introduction, pharmaceutical products become available to other countries earlier, many times years earlier, than they do to the medical profession in the United States. This is commonly referred to as the American Drug Lag. Cromolyn sodium, a drug used in the treatment of asthma, was available on the British market five and one half to six years prior to its introduction on the American market. Rifampin, an antitubercular drug of high efficacy and low toxicity, was available two years earlier.

The delayed dates of release on the United States drug market as compared to foreign ones can be attributed to more stringent pre-release toxicity testing as well as an inordinate amount of government paperwork and red tape. Problems, both financial and therapeutic, have resulted. The amount of money necessary for the additional research and development required by the Food and Drug Administration has created a financial burden for the drug industry. Each year that a potentially salable drug is withheld represents a loss of income to the pharmaceutical firm. Although not a serious problem at present, delayed release of drugs could develop into a disastrous therapeutic dilemma in that deaths could result. Suppose, for example, that an anti-cancer drug that cures is found.

Our present system relies heavily on preclinical trials, both in animals and eventually small, controlled groups of patients, to screen out ineffective or unsafe drugs. Extensive testing of drugs in animals assures a greater measure of product safety and protection than that afforded by earlier release and post-marketing surveillance. Studies have shown, however, that Great Britain, utilizing the post-marketing surveillance system, has not had any greater toxicity problem than the United States. Minimized toxicity reactions do not always mean optimum benefits. Individuals react differently to drugs, a science known as pharmacogenetics. To withhold a product which could conceivably improve a patient's condition defies common sense. Unfortunately, our present system is not equipped to handle the indepth post-marketing surveillance needed to make earlier release of drugs a workable reality.

The use of new drugs and new uses for old drugs should be a judgment of the medical profession. Physicians are in a better position to screen the risk-benefit ratios of drugs because they practice on a one-to-one relationship with the patient who is taking the medication. Since individual physicians do not normally see a large enough group of patients to determine efficacy in general, a data collection organization would be necessary to project a larger picture of the product. Under the present system medico-legal problems, malpractice claims, would be phenomenal, so that legal protections would be needed to prevent such occurrences.

Direction of drug release and usage should be in the hands of the physician. If the medical profession is to assume these duties, the system of drug controls under which we presently operate will have to be restructured. A physician council that would serve as an information collection agency to determine efficacy and toxicity will have to be established. The legal system will have to be revamped so that physicians will have a margin of safety from malpractice claims originating from adverse drug reactions. When these changes are affected, we will have taken a major step in improving therapeutic practice in the United States.

David A. Smith, M. D.
Medical Editor

"It's called Prescription!"

Rape—crime where victim is judged guilty

There is an article in this magazine that should receive the serious attention of every physician and especially those working in emergency wards or in collaboration with law enforcement agencies. It concerns itself with the problem of rape.

Whenever a person reports an assault the authorities are aroused and exert efforts to apprehend the offender. Seldom is there serious questioning of the validity of the complaint. When a woman reports rape she may be stunned and severly traumatized by the experience. She is often regarded almost as an accessory before the fact. She may be harshly questioned and if she knew the attacker before the event she may be made to feel that she is the guilty one.

I have happily had few experiences with rape victims but not long ago in discussing a rape case one physician commented, "Any woman as beautiful as she is who goes to a parent-teachers meeting alone is asking for trouble." He was more sympathetic to the responsible teacher than to the woman raped at knifepoint.

Dr. Peters' article presents many aspects of the emotional problems of the victim and it is unfortunate that an article to which he alludes cannot be included, but a copy can be obtained by requesting "The Psychological Effects of Childhood Rape" by Joseph Peters, M. D., in writing to The Center for Rape Concern, Philadelphia General Hospital, Mills Building, Philadelphia 19104.

Samuel B. Hadden, M. D.
Philadelphia

correspondence

Recommends uniform referral procedures

To the editor:

Confusion and unnecessary delay have surrounded a number of referred cases within the past several months, once again emphasizing the unsatisfactory situation with regard to medical consultation. Since all hospitals, large and small, general and university, in this commonwealth are involved with consultation and referral patients, a uniform procedure for submission seems to be a reasonable solution to this continuing perplexing problem.

In an effort to eliminate needless delay it is recommended that along with the usual brief history which accompanies referral cases there should also be routine submission of the initial surgical report, representative H & E slides, paraffin embedded tissue blocks and a small amount of representative formal in fixed wet tissue when available. In many instances appropriate radiographs are also essential and should accompany the request, especially when dealing with bone, lung or soft tissue lesions.

Obvious advantages include providing the consultant with some material afforded the original examiners and allowing for any desired special histopathological studies as well as providing file slides for re-examination and conference presentation. It is indeed the rare case where some wet tissue or a paraffin block cannot be supplied, and the paraffin blocks can be easily returned if necessary after a few appropriate sections are obtained.

The consultant should likewise exhibit the professional consideration of submitting a copy of his diagnositc impression to the original institution along with all material requested to be returned.

Not only does this cooperative method of communication represent the expected standard of professional courtesy, it is also essential for providing coordinated and expeditious patient care, no inconsequential factor in this day of close scrutiny by nonmedical reviewers.

C. Darrell Lane, M. D.
Reading

Commends Dr. Demko

To the editor:

May I congratulate you on the recent guest editorial (by Joseph N. Demko, M. D.) entitled "Alice in Wonderland" that appeared in the December 1974 issue of PENNSYLVANIA MEDICINE.

I have had exactly the same experiences that you have documented and I am absolutely certain that the problem will intensify in the future. I am sure that you are correct that we must stay together on these problems. Keep up the editorials.

Frederick R. Franke, M. D., D. SC.
Pittsburgh

Social, legal, and psychological effects of rape on the victim

JOSEPH J. PETERS, M.D.
Philadelphia

If a woman alleges assault other than rape, she is generally believed, examined medically and treated if necessary. Police and court response is direct and usually according to law. However, if the assault is sexual, that is, if she is alleging rape, the response may be quite different. No one wants to believe it. Her credibility is questioned and comes under scrutiny, particularly if the offending male is not a complete stranger. Hospital emergency rooms turn her away because administrative and professional personnel do not want to become involved in any subsequent criminal investigation and adversary trial.

In Philadelphia, for example, every hospital emergency room has been turning away rape victims for years and the police have simply become accustomed to escorting them to Philadelphia General Hospital, a municipal hospital which can turn no one away. At the four-year old PGH Center for Rape Concern, we recently treated a suburban woman who lives not very far away from this hearing room. She reported rape to her local police. They took her to the closest suburban hospital. After she had undressed for medical examination and it was learned that the offense took place during an automobile ride through Philadelphia, the local emergency room personnel and suburban police refused to proceed any further. They immediately had her dress and then transported her to PGH for treatment to prevent venereal disease and pregnancy, her chief concerns. Evidence and subsequent conviction proved that she had been sexually assaulted in various ways for several hours by several men and a woman in a car driven through Philadelphia. If the assault had not been sexual, or if the allegation had not been rape, she probably would have been dealt with closer to home. However, unless a rape victim is medically or surgically injured, most hospitals will turn her away.

Even a victim's family becomes irrational and inconsiderate when rape is alleged. The customary response of "What can we do to help?" is transformed into "What did you do to get yourself into this position?" They say in effect, "Why are you embarrassing the family this way?" or "How could you do this to us?" If she had been mugged, robbed, beaten or assaulted in any way other than sexually, such an accusatory response would seldom be evoked. The victim would be more likely to receive the support she so desperately needs to minimize immediate post-rape physical and psychological distress, isolation, and bitterness.

According to law, police should take everyone who alleges rape for medical examination to both treat and collect evidentiary material to found or unfound the woman's allegation. Instead, some policemen meet the victim with personal standards of credibility, and instantly unfound the rape allegation, changing it to a lesser charge. The extent of this practice is not known. It needs systematic study.

In 1973 we at PGH attempted a cross-cultural estimate by sending one of our social workers who is also trained in anthropology to study why in greater London (population 8.2 millions) in 1971, the reported rape rate was one tenth of the FBI Uniform Crime Statistics from New York City (population 7.8 millions). After extensive interviews with police in London precincts, she concluded that, since rape is the only crime other than treason which is punishable by life imprisonment, police are hesitant to even begin to process such a serious charge against a fellow man. They consider most allegations unfounded and unless the victim is a child, report them under a less serious charge. The social worker re-

ported that policewomen were no less stringent on adult women alleging rape than were policemen. This may indicate that the law must carry realistic penalties in order to be enforced at the police level, above all in those states which punish rape with a death penalty. There are 12 which do: Arkansas, Florida, Georgia, Kentucky, Maryland, Mississippi, Missouri, Nevada, North Carolina, South Carolina, Oklahoma, and Louisiana. We are finding that overkill can defeat the purpose of legislative reform with a problem so complex because enforcement becomes erratic.

What about the evidentiary requirements to substantiate a rape charge? Do these affect the way the victims report the offense or her post-rape social and psychological adjustment?

Penetration of the female sex organ, however slight, by the male's is an essential element of the crime of rape. When attempted rape was punished here in Pennsylvania only half as severely (5 to 10 years) as rape (10 to 20 years), defense counsel would argue failure to penetrate. When the punishment for attempted rape was made the same as rape, and rightly so, psychologically speaking, for both are essentially acts of aggression and hostility rather than erotic sexual acts, this defense became obsolete. Emission is rarely an evidentiary problem, even for offenders who have had a vasectomy or failed to ejaculate. Alkaline phosphatase tests to detect male prostatic fluid are simple and reliable. Furthermore, pubic hair combings, not routinely collected at PGH, may detect genital contact. Fingernail scraping may also help identify the offender, and victims are advised by some feminist groups to collect them.

Resistance is a moot question. While it may enhance the victim's credibility in the eyes of the police, no one knows yet the extent to which it further exposes the victim to bodily harm.

The most common defense in Pennsylvania is consent. Defense frequently argues that the victim did not resist except in cases involving minors or mental incompetents, whose consent is invalid and cannot be used to escape the charge. But what about an adult victim who consents under threat of physical harm? The fact is, in 50% of the several hundred rape cases we studied at PGH the victim reported than an object was used to intimidate her. Of these, 52% reported a knife and 30% a gun. We found that black victims more often reported intimidation with a gun, white victims a knife.

With such intimidation, there may be passive compliance to the sex act and few signs of resistance and force, particularly if the woman is not a virgin. Defense frequently plays up this aspect in order to successfully undermine the victim's credibility. In no other crime is the victim expected to demonstrate such signs of force and resistance to establish her credibility.

This article is based upon testimony by Dr. Peters before the Pennsylvania House of Representatives Select Committee to Study Victims of Rape. Dr. Peters is director of the Center for Rape Concern, Philadelphia General Hospital. He succeeded Samuel B. Hadden, M.D., as chief of group psychotherapy, dealing largely with small groups of sex offenders released on probation into the Philadelphia community. Dr. Peters is assistant professor of psychiatry and lecturer in sociology at the University of Pennsylvania. He is senior staff psychiatrist at the Institute of Pennsylvania Hospital.

Prompt complaint or outcry by a woman who alleges rape is also an element of credibility. Thus, if the victim fails to make a prompt complaint or immediate outcry, a presumption against her sincerity and the truth of her charge arises. In all jurisdictions which have adopted a statute of limitations for rape, the time is much shorter for rape than for any comparable offense. In Colorado it's 30 days; in Connecticut 3 months; in New Hampshire 6 months; in Massachusetts 12 months; in Iowa 18 months. Most crimes permit complaints years later without undermining credibility, but a rape victim is well advised to waste no time before reporting. She should not even bathe and dress first if she wants to be believed and preserve evidence.

Corroboration, which is additional evidence of a different character to the same point, is a varying requirement from state to state and is particularly inconsistent in the crime of rape. In 1969, when its statute required that both lack of consent and the fact that an attempt was made to penetrate be corroborated, there were 18 convictions for the original rape charge out of 1085 cases in New York State. These requirements were dropped in 1974. Whether conviction rates will increase as a result remains to be seen. While Pennsylvania does not have as stringent corroboration requirements, it did for a short period require the judge to charge the jury about the emotional state of alleged rape victims and their consequent unreliability as witnesses. Fortunately, under the protests of women, this law was revoked a few months after

enactment. We have found, however, that some judges still inadvertantly influence the jury in rape cases. We would recommend therefore that Judicial Sentencing Institutes, which focus upon the problems peculiar to rape, try to iron out the bias which still prevails among the judiciary. As we all know, most of them are males with masculine viewpoints. We think the law should require such training for judges who hear rape cases.

It is general knowledge that the previous chastity of the prosecutrix can become an issue during the course of a rape trial. In contrast, the offender's past criminal record independent of and unconnected with the current trial is not admissible. Several jurisdictions, one of which is Pennsylvania, specify that evidence of reputation only, but not of specific acts of intercourse unless they were with the defendant, is admissible. Utah and Washington State refuse to allow the introduction of evidence of previous unchastity in any form. Our people recommend the same for Pennsylvania.

During the past few years, the PGH emergency room has been receiving approximately 100 cases a month from the Philadelphia police. The Center for Rape Concern sends a social worker to visit the victim at home within a few days and schedules a psychiatric interview within 7 to 14 days. The victim is then followed up periodically for a year.

Analysis of several hundred first visits by social workers indicates the following about this population of victims. Sixty percent of the adults (18 years and over) and 40 percent of the adolescents (13 to 17 years old) show emotional distress. Children of 12 years and younger are so withdrawn that they cannot be comparably evaluated by a social worker. We try hard to have child psychiatrists see all children. One of the psychiatrists is male, two female. They were added specifically to see minors and their families. Prior sexual assaults were recorded for 8 percent of the adults, 11 percent of the adolescents and 33 percent of the children. The number of non-sexual assaults reported was 38 percent in adults, 49 percent in adolescents, and 13 percent in children. Victim complaints of physical distress from the rape is highest in adults, next in adolescents, and least in children. Fear of V.D. is highest in adults, less in adolescents, and least in children, while fear of pregnancy was higher in adolescents than adults and seems to be non-applicable in children. Other social worker findings were: changes in eating habits, 57 percent adults, 25 percent adolescents, none in children; sleeping patterns, 68 percent adults, 30 percent adolescents, 7 percent children; fear of offender retaliation, 66 percent adults, 53 percent adolescents, 33 percent children; fear of being raped again, 66 percent adults, 62 percent adolescents, 7 percent children.

The examining psychiatrists found one or more post-rape changes in 73 percent of the cases during initial interview, which takes place a week or two after the first home visit. Fear of strange men was reported by 27 percent; decreased sexual desire by 22 percent; trouble sleeping by 20 percent; increased number of frightening dreams by 20 percent (higher in adults than minors). Seventeen percent were more withdrawn emotionally (higher in minors than adults); 10 percent feared offender retaliation for reporting; 10 percent feared all men; 10 percent feared being raped again; 10 percent were clinically depressed. Smaller numbers reported feeling isolated, ashamed, guilty, afraid of being alone, or worried about negative opinions of significant people in their lives following the rape. Extensive social and psychiatric background data is being studied in order to correlate these changes with prerape personality and circumstances surrounding and following the assault. These will require intensive study and data analysis before rational conclusions can be drawn.

In 1970, under the author's supervision the Center for Rape Concern was started at PGH by adding six social workers to an established team of six psychiatrists, two research psychologists and a sociologist who since 1955 had been researching and treating groups of convicted sex offenders probationed into Philadelphia County.

As we listened to the stories of offenders, and as I uncovered childhood rape incidents from my continuing private psychiatric practice of twenty years, I became increasingly aware of the general failure of families, hospitals, professionals, and the criminal justice system to deal adequately, or even rationally with anyone who alleges rape. Furthermore, the irrationality and lack of credibility heightens when the offender is not a stranger. And in the case of minors who are 45 percent of the PGH population of over 1,000 victims a year, the majority of offenders are *not* strangers. In private psychiatric practice, 90 percent of victims twelve years of age and younger were assaulted by acquaintances and family members, fathers and stepfathers included.

But what about more obvious social, legal, and psychological problems faced by victims who allege rape? Can society effectively deal with them through intelligent legislation? Legislation was introduced in both the State Legislature and the United States Congress in the last sessions. Although the bills died when the legislative bodies adjourned, it can be expected that similar proposals will surface in the new sessions of the State Legislature and the U.S. Congress. Support of such proposed legislation to assure its passage quickly will make available the means to solve the problems of victims who allege rape.

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Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

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Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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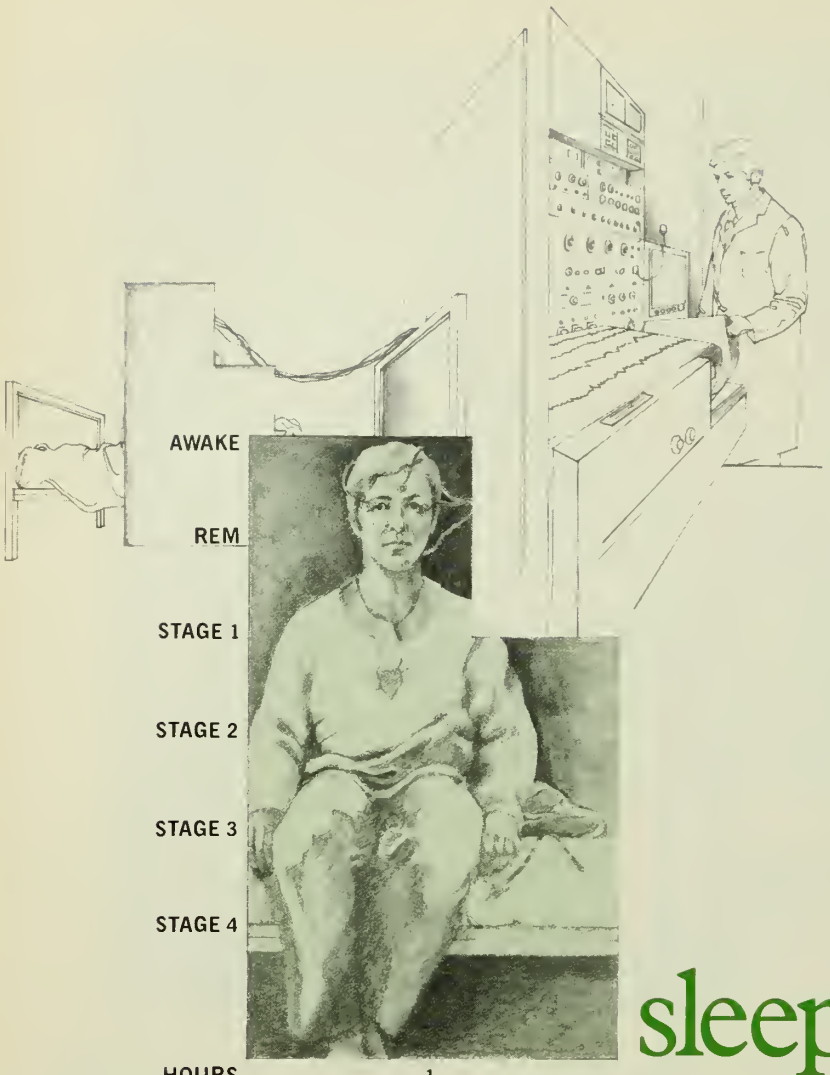

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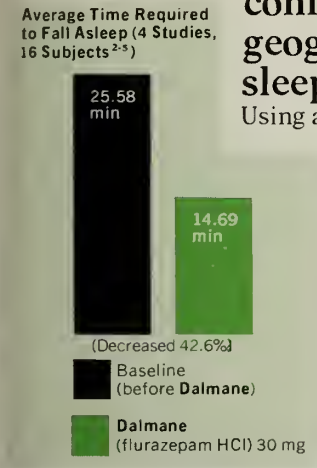
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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

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- induces sleep within 17 minutes, on average
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5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

KEEP THE HYPERTENSIVE PATIENT ON THERAPY KEEP THERAPY SIMPLE WITH DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Just 'Dyazide' once daily or twice daily
No inconvenient potassium supplements
Nor special K^+ rich diets needed as a rule

Two prime reasons patients drop out of hypertensive therapy are (1) the patient failed to understand directions, and (2) the regimen was overly complicated. Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

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When serum cholesterol demands attention...

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- Diet control
- A proven cholesterol-lowering adjunct to diet*
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(sodium dextrothyroxine)

An agent for low density lipoproteins, "type II hyperlipemia," in euthyroid, non-cardiac patients.

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Choloxin® (sodium dextrothyroxine)

The Lipid-Lowering Agent with Once-A-Day Dosage

Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES INC
Deerfield, Illinois 60015

practice management

Collection at the source can be professional

LEIF C. BECK, LL.B.
VASILIOS J. KALOGREDIS, J.D.
Bala Cynwyd

While we have written previous articles on collecting for medical services, one aspect of that subject continues to deserve particular attention. It deals with collecting for a service in the office at the time the service is performed, known as "collection at the source," or more commonly, "over the counter."

Why is it so important?

Prompt collection of accounts is particularly important in these times of such tremendous inflation. First of all, patients' own finances are becoming stretched to the point that all creditors are fearing non-payment or extended delay. The physician has typically remained low-key in his collection attitude, a sign of the medical profession's placing health care over commercialism, but he must also pay his bills, support his family and fight the same inflationary pressures. Hence, the physician should see to immediate collection as his way of professionally assuring that he will not be placed at the end of the patient's list of debts.

Second, with inflation running at perhaps 10 percent per year, the value of an account receivable dwindles by about 2½ percent for every three months. That bill's value shrinks with collection delays, depriving the doctor of funds he might invest in unusually good interest income returns. This is particularly appropriate if the physician can syphon the funds collected earlier in the year into his tax-exempt retirement funds (Keogh or corporate).

The values of over-the-counter collection should be obvious, for they can be described simply. For instance, collection at the source is a 100 percent collection; but even if a practice has a good collecting experience (perhaps a 95 percent ratio), the failure to be paid promptly causes each dollar to be worth only 95 cents at best. In that sense, only a dollar actually collected can be an assured part of the practice's income.

Furthermore, the costs of sending bills is substantial and can be completely avoided by collection over the counter. Computer billing systems charge from 25 to 50 cents per bill and there are personnel costs involved as well. We would conservatively estimate the cost of non-computer billing to be comparable when including postage, duplicating machine costs, substantial personnel time and supplies. Rebilling of the many patients who have not paid within the first billing cycle, of course, doubles the cost. How much better to be paid immediately and keep these office overhead costs to a minimum!

While the importance of collection over the counter should be obvious to primary care, office-based practices, surgical and other hospital-oriented physicians often discount the concept. They suggest that the bulk of their incomes are earned in the hospital and are paid by third party insurers. While that may be correct, these doctors' arguments against at-the-source emphasis are often invalid.

While most of the *dollars* earned by orthopedic surgeons, urologists, ophthalmologists, OB-GYN men, etc. might be earned in the hospital, a high percentage of his monthly *bills* mailed are nevertheless for office visits. We recently surveyed a three-man orthopedic surgery practice grossing $400,000 of which only $70,000 came from office practice. Nevertheless, we determined that the office saw an average of 1,400 patients a month and accounted for an overwhelming majority of the monthly billings. Furthermore, a high number of those office visits were uninsured, making the usefulness of immediate collection even greater.

We believe that virtually every practice in which patients visit the office should stress this collection philosophy. To whatever extent it is made successful, this is an improvement in that office's efficiency. The only possible exception might be psychiatrists' offices, since attitudes of how billing and collection ties to patient treatment vary.

Is it "unprofessional?"

Various doctors protest that urging immediate payment is somehow "unprofessional," that it demeans the practice to dun for immediate cash. This is simply not true so long as the request is made in a polite, discreet manner. The doctor must be sure that his receptionist make the request properly; thus he can protect against such problems.

In this respect, we feel strongly that over the counter should be made a strong policy of *request* for the patient's cooperation, but absolutely not a prerequisite for treatment. The physician should, we believe, extend credit to his patient who so requests, for his main professional obligation is to render good care. We do not expect any of our clients to create a 100% success—50 percent is in fact a good goal.

We have seen effective collection approaches in all types of offices and in all ranges of communities. The old objection that "my patients are high income people who would not accept such an approach" simply does not stand up. It is a matter of proper patient education.

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd, Pennsylvania.

Creating the over the counter habit has been accomplished in the highest and the lowest income areas.

Doctors too often protest that their patients are not used to an effective over the counter request, and hence the policy would not be successful in their offices. It is, however, merely a matter of properly setting forth the new policy and then giving it some time to become established.

The change will not come overnight. Patients are often surprised and unprepared to pay when they return to an office which has just adopted the policy. A friendly description of the change and a request to honor it on the next visit should create the proper response in most patients in the future. Thus, the ratio of collections at the source should pick up over perhaps three to six months' time.

Some patients will simply refuse to comply. We believe this is a normal situation and that they should be billed, although continuing reminders of what would be appreciated might convince some of them without losing their good faith.

Training and supervising the receptionist

The key to the system's success is the person at the desk. The receptionist must, therefore, be properly trained as to how various patient responses should be handled. The doctor should take a direct, personal interest in this matter. He should discuss with his receptionist the importance of collection at the source and how she should encourage it. This might even include providing her with a written list of questions and answers for various situations which will repeatedly arise.

A receptionist should never, for example, ask, "Would you like to pay this now, or shall we bill you?" Much better is, "Would you like to pay this by cash or by check?" To a request to be billed, the aide might reply, "Certainly we will, but we would appreciate your coming prepared to pay in future visits, as it is our policy to request prompt payment," and so on.

A good policy requires that one person be primarily responsible for the receptionist duties. She can then be held accountable for the success or failure in collecting at the source. While she must obviously be relieved by others for breaks, lunches, illnesses and vacations, the idea of job specialization is important to an effective office. It is not, by the way, unusual to change job roles when one receptionist has simply not handled over the counter collection efforts discreetly or effectively.

Use of a fee slip

The program also requires that the receptionist be aware of what services were performed for the patient preparing to leave the office. This requires use of a "fee slip" on which the doctor or nurse must mark each procedure or service performed for the patient. The patient should be asked to take the slip to the receptionist upon leaving, thus assuring both the information and the patient's presence.

There are a variety of systems effectively combining fee slips with patient billings and, in turn, with accurate bookkeeping. For smaller practices (perhaps up to four or five doctors), these are very well incorporated into "peg-board" systems which we believe are excellent. For larger practices, the fee slips can instead be effectively combined as part of the posting machine or computer input systems.

Use of a visual aid

We are generally opposed to practices posting signs announcing the requirement to pay upon leaving the office. Nevertheless, receptionists struggling with the proper presentation to patients will often find some sort of visual aid to be helpful. It will support her as she describes the office's policy.

We suggest in such cases the preparation of a small, perhaps 4″ x 7″, cardboard card containing a printed legend such as: "The office's policy requests all patients to pay for their visit before leaving the office. Your cooperation will be appreciated."

A visual aid of this type is unobtrusive and consistent with a medical office's image. And yet it tends to provide some tangible support to the receptionist.

Keeping track of the results

A system works best if the person responsible for its success knows her performance is being measured. This idea of "accountability" holds true for a receptionist and her efforts at developing collections at the source.

The doctor-employer should thus maintain a record-keeping system which periodically (generally monthly) shows how much of the total receipts have been collected in the office and by mail. The higher the percentage of in-office collections, of course, the better the receptionist is presumably promoting payments at the source.

Similarly, a month-to-month record of the ratio collections in the office to total charges for office procedures will demonstrate the receptionist's effectiveness. We find that most offices should reach at least 50 percent on this test, while many progress to 70 percent or 80 percent figures. Absolute (100 percent) effectiveness is virtually impossible, especially since some amount of work will be paid for by third party insurance.

The doctor should share these month-to-month records with his receptionist. If the percentages are increasing, he should compliment the performance and set new goals for the succeeding months. If the numbers are decreasing, however, he should point out the objective evidence and attempt to correct the problem.

Conclusion

Collection at the source is neither unprofessional nor unimportant. It is instead a vital element of making a medical practice cost-effective within the confines of good taste. Making such a program succeed, however, requires some physician attention. We hope the ideas of this article will help him properly channel those efforts. □

Health maintenance organizations—some issues

ROBERT L. ARCHER
Harrisburg

'It is the Capital Blue Cross position that the HMO provides a unique opportunity to modify the health care delivery system in a rational, moderate fashion primarily through better organization.'

In early 1970 the federal administration authored a "Health Cost Effectiveness" bill which was presented to the House Ways and Means Committee. Contained in that bill was a concept referred to as the "Health Maintenance Organization," an alternate delivery mechanism. This term had been coined a few years earlier by Paul M. Ellwood, Jr., M. D., now president of Health Services Information, who foresaw that one of the solutions to the alleged fragmentation in delivery of health care services would be to initiate a system of organizations as umbrellas under which a broad range of health care services would be delivered. Particularly, these services would include hospital, physician and prevention.

Although the term HMO might be new, it was predicated upon existing organizations such as the Kaiser Foundation, the Health Insurance Plan of Greater New York and certain medical care foundations, such as the San Joaquin Foundation for Medical Care in California. These three organizations, though structurally different, embody certain key concepts in their approach to delivery and financing of health care. These include: (1) "group practice" wherein physicians are tied together organizationally, either under a common corporate roof or through another means of coordination such as membership in a foundation; (2) the provision of a "broad range of health care services" under a prepayment mechanism, particularly as these services relate to care in a physician's office or clinic; (3) a financing method often referred to as "capitation," which means that for a stipulated sum paid, usually monthly in advance, the subscriber is guaranteed all the services he demands.

It follows that promising to deliver all the services a subscriber might demand places the organization at considerable risk. Whereas usage of hospitals can be predicted, use of medical services is not so easily defined. As Dr. Sydney Garfield, founder of the Kaiser program, described so well, there is a great body of people using health services which he classified as "the worried well." These individuals can and do clog up the delivery system by their excessive demand when, in fact, their relative need for services is generally low.

Mr. Archer is director, Provider Affairs Division, of Capital Blue Cross which is the Blue Cross Plan serving nineteen counties in central Pennsylvania. He is responsible for liaison operations between the Plan and providers of service. He also has principal responsibilities with Medicare, the Plan's utilization review program, and Plan community relationships. Mr. Archer has visited California and New York to investigate the operation of their Health Maintenance Organizations.

The HMO concept has caught the fancy of several politicians influencing the direction the federal government is taking concerning intervention in the health care system. Interest has been created not only by the novelty of the concept, but by the results from a brief study performed under the auspices of the Health Manpower Commission in 1968 which determined that group practice (Kaiser-Permanente) resulted in a 20% cost savings. Findings relevant to cost effectiveness of the HMO are demonstrated by an evaluation of Medicare and Federal Employee Program statistics which indicate considerable savings in institutional use when services are delivered under an organization such as an HMO. These statistical reviews cannot be definitive because there are so many variables to consider. It is sufficient to say that an organized approach to delivery of health care services where peer controls are established to assure that only needed services are provided should result in a more rational distribution of health care resources.

In that context, it appears that HMOs have a considerable chance to make an impact upon the health delivery system. The impact will no doubt be of a magnitude greater than their aggregate because of their very existence. In other words, just publicity of success or failure will affect the way physicians practice in a community where a Health Maintenance Organization exists.

HMOs have been given a significant boost through passage of Public Law 93-222, "The Health Maintenance Organization Act of 1973." This title makes available for developmental purposes $375 million over the next few years primarily for feasibility studies, grants, and loan guarantees for initial development and operation costs. This paper evaluates some of the issues surrounding Health Maintenance Organizations with particular emphasis on limiting factors which seem to go unnoticed in the midst of rhetoric.

Constraints

At the present time, there is not one organization in the United States that would qualify as a "certified" Health Maintenance Organization under Public Law 93-222, but there are nationally 172 which may qualify (four in Pennsylvania including Temple University and South Philadelphia in Philadelphia, Geisinger Medical Center in Danville, and Centerville Clinic in Centerville). There are essentially two constraints. The first is that the benefit structures of these present organizations do not fall within the federal model. Second, the operating structure is mainly controlled by providers of service. Thus, there is considerable concern by existing programs to influence the soon coming regulations so their method of operation will not be altered and the benefit structure will not require so extensive an expansion as to drive rates too far beyond present limits. Obviously, providers operating these organizations do not wish to give up their autonomy to outside interests, nor do they wish to be priced out of the market. On the other hand, they do want the designation as "qualified" HMOs so employers will be required to put their names on the ballot when offering a health care program to employees.

Nothing in the law (P.L. 93-222) requires enrollment in an HMO since at the present time, the concept of dual choice remains persistent—that is, the employee should always have the option of joining or not joining. Employers are apprehensive because there is little doubt the HMO alternative can drive up present fringe benefit costs. For example, a comprehensive Blue Cross/Blue Shield program with Major Medical costing about $35 and perhaps being paid in full or part by the employer will be matched against an HMO premium structure. In the central Pennsylvania area this may be over $60.00 per family using traditional rating factors. Thus, employers would be pressured to increase their contributions.

Conceptions and misconceptions

1. Decision to Enroll—The decision to join the HMO is frequently made by the wife. She typically maintains the linkage with the family practitioner and if her physician, the one who delivers the children and takes care of the colds, is not a member of the organization, the family is generally reluctant to opt for a structured system where these linkages may be discontinued.

On the other hand, individuals with no formal linkage may tend to opt for the HMO because they are assured of receiving services when needed. It appears that the growth of Health Maintenance Organizations using the variety of present models is generally slow because of the significant change in the family's relationship to the system and, of course, the usual increase in cost.

2. Prevention and Education—There is a great deal of rhetoric surrounding the HMO, particularly in relation to consumer education and preventive health services. These are kinds of services envisioned by the drafters of the present legislation. Unfortunately, there are little or no data to support the concept that preventive health services are effective nor are there data to support the concept that consumer education has an effect on the eventual delivery of services or the quality of life. It seems logical that some preventive measures such as routine pap smears and consumer education should be included in HMO services to the extent that the consumer knows how to use the health care system.

3. Essential Difference—Aside from the two foregoing aspects, the most significant difference between the present fee-for-service system, or "prepayment" through Blue Cross and Blue Shield, is the addition of one primary benefit—coverage for office and clinic visits. Existing HMOs, however, almost uniformly require a copayment for these services, for example, $1 to $3 per visit. These fees are employed not to deter usage but to shift part of the cost to the subscriber.

4. Community Rating—A peculiarity of HMO philosophy suggests that rating be on a community-wide basis. This is not necessary for a successful venture. Kaiser, for example, over the years has aimed their enrollment at large employee groups. From an underwriting perspective, these represent the best risks in terms of health and usage of services. Community rating, on the other hand, implies mixing the higher cost poor risk components (such as direct pay subscribers) with the good risks to achieve a leveling effect. Employers and commercial insurance firms do not advocate this method because of the cost implications.

Briefly, the factors employed in establishing rates include projecting the number of days of institutional care required per 1,000 subscribers, and in this instance projecting the number of office visits per 1,000 subscribers. The values derived and applied to known cost factors are subsequently reduced to a cost per member month which may be further modified into average values for family units without regard to family size. Interestingly, Blue Cross and Blue Shield Plans have generally adhered to the community rating concept until recent years when commercial competition forced experience rating. In a way, we have come almost full circle.

5. Incentives—HMO proponents continually emphasize that placing the delivery organization at risk will require it to operate economically and fixing the amount of income the organization will receive will en-

courage the HMO to deliver services such that operating cost will not exceed income. Thus, at the end of the accounting period any surplus can be distributed among those participating. This concept makes little sense when examined closely. In effect, what happens via the incentive process is nothing more than the creation of a "mini" insurance company and by necessity the requirement that this "mini" insurance company set aside reserve funds for potential future losses. This is precisely what Blue Cross and Blue Shield do. The Plans prospectively set a rate for a predicted amount of service, including a reserve factor. That rate holds until such time as costs (inflation) exceed income; then the rates are adjusted. At one time the disadvantage in the Blue Cross and Blue Shield prepayment system was that there were few incentives to providers to control cost. That is not true today; one can quickly point to a host of economy programs present in the hospital-Blue Cross relationship.

Unfortunately, the examples alluded to by proponents of the incentive mechanism, notably Kaiser, do not realize that the so-called incentive payment is a function of the rate. Rate-making at Kaiser is determined by computation of total costs, including projected hospital expense, physicians' income and ancillary service cost, and a sum of money earmarked for incentive payments at the end of a certain period. The result is that in every year these incentive payments are made by Kaiser and rates adjusted upward to assure their continuation.

Cost effectiveness

It is generally accepted that institutional care is overutilized. This is less because of intent by physicians and more because of traditional methods of delivery and lack of an administrative mechanism to oversee delivered service. Presently, there are mechanisms operating effectively which have resulted in significant decreases in institutional care utilization. Using estimated figures, in the usual insurance program institutional services account for 55% of the dollar while professional services account for 45% of the dollar. In the HMO concept, these percentages are reversed. Thus, if there is any incentive in the HMO, it is that there is no economic advantage to the patient or the physician to admit the patient to the hospital in order to receive reimbursement. Also, there is a professional risk in the event the physician admits a patient unnecessarily and is so judged by his peers.

This reversed financial effect is what makes the HMO attractive because it suggests more personal service. We cannot say, however, which way the quality of life or health is improved. Neither can we say whether real dollars are saved.

Implications

There are certain implications which must be considered by organizations contemplating the development of an HMO. In this connection an assumption is made that the motivating force would be typically an existing community resource such as a hospital and that in central Pennsylvania Capital Blue Cross would be involved.

1. Medical Staff—The hospital must assess the attitude of the medical staff toward such a development. Generally speaking, physicians are reluctant to submit to a regimented system which may impinge upon their ability to practice their specialty and which may directly affect their personal economics. A developing HMO therefore must describe an organization which will not significantly affect these two concerns.

In light of the increasing attention focused on peer review, the first issue that physician privilege should not be trammeled may be academic. We already have peer review operating systems in the Capital Blue Cross/Pennsylvania Medical Society Regional Medical Review Committee (RMRC) and Professional Standards Review Organization (PSRO). However, since there is little emphasis on office or clinic care, peer review must be extended from the hospital to the office-clinic setting. Consequently, participating physicians must be willing to accept peer review decisions and, of course, participate in the peer review process individually. In return, physicians must have a voice in policy making and the HMO does provide this opportunity.

From an economic standpoint, there is nothing to prevent physicians from participating in the HMO and also providing services to non-HMO patients. In fact, there is little need for participating physicians to even be aware which financing mechanism the patient presents. His fundamental commitment to the HMO is little more than agreeing to work with his peers to assure conservative use of health care services and facilities in accord with the dictates of his peers. It is not necessary that he be a salaried physician, nor is it necessary that he continue fee-for-service in the event that some doctors already in a group practice arrangement prefer to use the salary method of payment. Thus, the financial alternatives are many and can coexist.

2. The Community—Community support is essential for any endeavor which involves health care delivery. The HMO should reach into the community, explain its objectives, and enlist the support of community leaders. It would be appropriate to create advisory bodies composed of various community elements, including other providers, with meaningful participation and commitment. A physician in an ongoing HMO recently noted that while the community council occasionally wrangled with the HMO policy makers, it kept their rates realistic and the program in touch with the community. Final policy making, of course, would rest with the HMO.

3. Feasibility—"The Health Maintenance Organization Act of 1973" provides money for feasibility studies. In the typical situation, such a study is unnecessary and would merely serve to delay the decision-making process. Provided the rating structure is not burdensome, it is enough to have medical staff and community commitment.

4. Financial Risk—Blue Cross and Blue Shield are amply prepared to assume the entire underwriting risk in connection with a developing HMO. As noted previously, the HMO is a "mini" insurance company. Blue Cross and Blue Shield believe this is an area in which they have special expertise, just as hospitals and physicians have special expertise in delivery of health services.

5. Rating—Blue Cross and Blue Shield have the technical expertise to develop rates for any range of services contemplated in an HMO delivery scheme. Furthermore, Blue Cross/Blue Shield Plans are of the opinion that, given the organizational arrangement and the willingness of physicians to conduct peer review at all levels of service, the traditional ratio of hospital service cost (55%) to medical service cost (45%) can be shifted. Therefore, because of the increased emphasis on physician office and clinic service, substantial savings in high cost hospital care can be realized, thereby providing funds to finance a more extended benefit program. For example, in the Capital Blue Cross service area, Plan subscribers presently use about 820 hospital days per 1,000. It is a reasonable assumption, using the HMO format with physicians performing peer review at all levels, that this volume of days per 1,000 can be reduced initially to approximately 700 days, 13 percent.

Accordingly, it would be the Capital Blue Cross and Pennsylvania Blue Shield objective to provide the community with an option to present 120-day comprehensive Blue Cross coverage, including Prevailing Fee Blue Shield and Major Medical. The option would be an HMO package of benefits encompassing all of the foregoing plus inclusion of office and clinic visits, prescription drugs (in the base program rather than Major Medical) and certain alternate institutional services such as alcoholism rehabilitation, mental health services, home care and physical rehabilitation. The rates for these two alternatives with certain copays could be identical.

6. Administrative Cost—One of the advantages to the utilization of Blue Cross and Blue Shield as fiscal administrator is economy of operation. The administrative structure for Capital Blue Cross/Pennsylvania Blue Shield services is already bought and paid for and need not be duplicated. The Plans have the data processing capability to provide statistical and quality evaluation data and the accounting capability to handle all financial matters. They have the communications staff necessary for community relations and subscriber education so that expenses of this nature can be minimized for the HMO. It is significant that Capital Blue Cross has an administrative expense of less than 5% of the subscription rate with the remaining 95% available for benefit payments.

7. Marketing—It would be the intent of Capital Blue Cross and Pennsylvania Blue Shield that the HMO alternative be offered to all existing Blue Cross/Blue Shield groups which presently account for 46% of the central Pennsylvania population. It would also be the Plans' intent to negotiate with non-Blue Cross subscriber groups to market the HMO side-by-side their present commercial insurance coverage. Similarly, the Plan would make a direct offering to any member of the community to enroll on a direct pay basis. The Plans currently have offices in principal medical trade areas and suitable arrangement would be made to expand the marketing staff to handle any additional duties.

8. Financial Relationships—Although there is little to demonstrate that payment of an incentive assures efficiency, the Plans would find acceptable a system of sharing the excess of income over cost of operation. However, they would prefer to use excess income as a means to expand the benefit structure or reduce rates.

Conclusion

One objective of this paper has been to present as fairly as possible sufficient details concerning HMOs against which policy decisions can be made. It has not been the purpose of this paper to lead the decision. Nevertheless, serious consideration must be given HMO involvement by all parties if only because the health care industry is faced with a tremendous surge of interest in its affairs at the national and local levels. Many have said that we are in a health care crisis, costs for health care are out of control, there is a maldistribution of manpower, the health care industry requires more regulation, people are not receiving necessary care and so on. There is substance in each of these assertions, yet it is unfair to charge the health care system with all of these faults when even the most liberal interpretation suggests that they can seldom be identified except as existing randomly from time to time. The nature of federal legislation like Public Law 93-222 is such that it affects all citizens equally though not usually impartially and cannot be ignored.

If the system is due for a change, or about to change, we must be prepared to accommodate accordingly. Accommodation to change should not be confused with passive acceptance; it should rather be viewed as an opportunity. It is the Capital Blue Cross position that the HMO provides a unique opportunity to modify the health care delivery system in a rational, moderate fashion primarily through better organization. To some, it may appear that the HMO is a radical departure from traditional delivery systems. That would be so if conditions of operation required change in the consumer-provider relationship. It does not require such change, nor does it necessitate change in the consumer-financer relationship. What the HMO does offer is an opportunity to provide a wider range of health services to the consumer, not by federal mandate but through voluntary, cooperative effort. Thus, the HMO presents a transitional opportunity between present health care system organization and how it may be organized in the future. Without participation in this transitional opportunity, the system may very well find itself locked in by legislation to a tax-supported, government-directed program with little opportunity for evolution. □

Orthopedic problems in hemophilia

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Although intra-abdominal and intracerebral hemorrhages in hemophiliacs are life threatening, these complications are relatively rare compared to the progressively disabling hemorrhages into the joints and muscles. The problem of keeping the patient a functional, active, and employable citizen becomes a great task for today's physician.

Hemarthrosis

Joint hemorrhage usually follows trauma. However, in the hemophiliac this trauma can be rather trivial, such as turning over in bed. The initial lesion is synovial or subsynovial tissue hemorrhage which provokes an inflammatory reaction resulting in a joint effusion.

After repeated hemorrhages, the synovium, the subsynovial tissue and joint capsule thicken resulting in rigidity of the joint and progressive limitation of motion. This reaction progresses, damaging the articular surface and subchondral bone. This usually begins as a marginal erosion of the cartilage by the hyperplastic synovium very similar to that seen in rheumatoid arthritis.

In the child with open epiphyseal plates, the hyperemia of the joint area results in accelerated maturation of the epiphysis with hypertrophy. After repeated episodes of hemarthrosis, the joint fails to return to normal motion. Progressive thickening and deformity of the joints results and becomes the chronic stage of hemophiliac arthropathy.

If the synovial lining of the joint remains thickened, it becomes more susceptible to minor trauma resulting in frequent repeated hemorrhages. In addition, as a result of muscle wasting, the joint becomes more susceptible to recurrent hemorrhages, particularly the quadriceps following knee injury and loss of motion secondary to contractures or other intra-articular changes.

X-ray findings

X-ray findings in the hemophiliac are variable depending on the stage and degree of joint involvement. In early stages, the x-ray will show nothing more than evidence of swelling of the synovial sac secondary to hemarthrosis. However, with repeated episodes, there may be periarticular osteoporosis, subchondral cyst formation, thickening of the synovium, invasion of the articular cartilage, narrowing of the joint space, and finally, the typical appearance of advanced osteoarthritis. There can be subluxation of the joint, widening of the intercondylar notch of the femur, enlargement of the radial head at the elbow, and squared off inferior pole of the patella. In the lower extremities, leg length discrepancies can develop secondary to either overstimulation of the epiphysis or premature closure of the epiphyseal plate so that the extremity becomes longer or shorter than the normal side.

Dr. Stein is attending orthopedic surgeon and is active in the Hemophilia Program at Albert Einstein Medical Center. Dr. Kajani is director of the hematology laboratories and the Hemophilia Program at Albert Einstein Medical Center and Moss Rehabilitation Hospital. This is the fourth in a series of articles on hemophilia.

Management

Management of the hemophiliac is multidisciplinary. When the patient is seen, the joint is examined for swelling, pain or direct tenderness, and the degree of loss of motion is evaluated. The absence of significant tenderness in a joint suggests a joint effusion rather than a hemarthrosis. However, on occasion, the patient with a chronic arthritic joint may present with a painless nontender hemarthrosis.

The aims of treatment are to stop bleeding, relieve pain, maintain and restore function, and finally, to prevent the development of a chronic stage. In order to stop joint bleeding, replacement of the missing factor is necessary, and the joint is immobilized until the vessel or vessels that have initiated the joint hemorrhage have healed. In order to maintain and restore joint function, the development of a good rehabilitation program for the patient in terms of muscle strengthening exercises, as well as range of motion exercises, has to be provided. With treatment methods as outlined previously, along with the consideration of aspiration of the blood from the joint, the prevention of chronic joint changes or the chronic stage of hemophiliac arthropathy is feasible.

Joint aspiration

The decision to aspirate a hemophiliac joint is based upon the

physician's experience. At our center, this decision depends upon several factors. The factor of prime importance is the size of the hemarthrosis. Small hemorrhage into the joint with known chronic arthropathy may not be feasible to aspirate because of loculation of the joint space. An attempt to aspirate such a joint may cause further hemorrhage. The time interval between the onset of bleeding and the time of aspiration is of great importance. If the hemorrhage is older than twenty-four hours (due to formation of clots) aspiration will probably fail to evacuate the joint completely.

In a large hemarthrosis of the knee joint, especially in a patient who does not have significant chronic arthropathy, aspiration should be carried out. The elbow and ankle joints should not be aspirated unless there is significant amount of hemorrhage. Aspiration is usually done after the patient has received his replacement therapy.

After the patient has received his factor replacement, whether or not he has had joint aspiration, the joint is immobilized, usually with the use of a posterior plaster splint. If a lower extremity is involved, the patient is placed on crutches. The length of time depends on the degree of hemorrhage and whether or not aspiration has been accomplished. If aspiration has not been carried out, the patient is reevaluated in three to four days, and it is usually feasible either to begin weight bearing with a posterior plaster splint with the knee in extension, or partial weight bearing, if an ankle is involved, with the use of crutches. Depending on discomfort and absence of any signs of recurring hemorrhage, further gradual mobilization is carried out. A rehabilitation program consisting of strengthening exercises and increasing range of motion exercises is then begun. If the knee has been aspirated, the patient usually returns in two days for another dose of his missing factor. Immobilization is continued for at least a week. Failure of the joint hemorrhage to be completely resolved by the end of a week usually indicates that the immobilization was inadequate, that the amount of replacement therapy was inadequate, or that a recurrence of joint hemorrhage was not recognized.

Treatment of chronic hemophiliac arthropathy is difficult. With flexion contractures of the knee, active physical therapy frequently is insufficient to correct the deformity. Intensive rehabilitative exercise programs are required. The use of braces for prolonged periods of time should be avoided. However, when ambulation is not otherwise feasible, they must be used.

Intramuscular hemorrhage

The incidence of intramuscular hemorrhage is much less than that of intra-articular hemorrhage. However, it is still the second most frequent site of bleeding in the hemophiliac. Hemorrhage into the muscle must be distinguished from superficial hemorrhages into the subcutaneous tissue and skin. It should be noted that one of the major causes for intramuscular hemorrhages is intramuscular injections and these certainly should be avoided in the hemophiliac.

The rapidity of symptoms is determined by the degree of tension that is built up in the muscle compartment. The size, shape and fascial confines of the muscle group will tend to determine the eventual limit of the hematoma. Obviously, the smaller these fascial confines, the quicker the patient will become symtomatic. Small hemorrhages beneath the very firm and close fascial plane of the iliacus in the pelvis can produce pain; whereas, more extensive hemorrhages in the calf, buttock, or quadriceps are required before significant amount of pain can develop.

Except for the case of the iliacus hematoma, hemorrhage into the muscles are easily palpable. These are usually followed by protective spasm and contraction of the muscles. In the case of the iliacus, the hip is usually held in flexion and external rotation. With bleeding into the forearm, the muscle spasm results in flexion of the wrist and fingers, and in the calf, equinus deformity of the foot. Attempts to correct these contractures during the acute phase should not be made.

The treatment is similar to that for joint hemorrhages, namely, the adequate replacement of missing factor and immobilization of the involved muscle. Prolonged rest should be carried out for iliopsoas hemorrhages, but for other muscles, immobilization should be discontinued as soon as possible. This will depend on decrease in the amount of swelling and muscle spasm as well as the absence of pain.

Neurological involvement

Neurological and vascular involvement must be observed following intramuscular hemorrhage. Volkmann's contracture can be seen in the upper extremity following hemorrhage into the flexor muscles. However, contracture can be due to fibrosis of the flexor muscles rather than arterial compression. Particular care must be taken in the treatment of hemorrhage into the forearm and calf to prevent permanent contractures.

Mobilization should be quick enough to prevent formation of permanent contractures. Nerve involvement secondary to hematomas can occur. In our experience, most of these have been self limited. Occasionally, when true Volkmann's ischemia occurs, the nerve damage will remain permanent. The femoral nerve is the nerve most commonly involved, and involvement usually occurs with iliopsoas hemorrhage.

Fractures

Fractures have been found to heal normally provided adequate replacement therapy is given early. It should be given for at least a week in routine fractures and up to two or three weeks with open fractures or those requiring open reduction. The patient with plaster immobilization must be observed carefully for possible neurovascular complication.

Pseudotumors

One of the dreaded complications in the hemophiliac is the development of pseudotumors which

are cystic lesions arising from subperiosteal hemorrhages. Occasionally, they may arise from intraosseous hemorrhages. Pseudotumors of the small bones of the hands and feet usually can be treated by replacement therapy and immobilization for a prolonged period of time. Occasionally, x-ray therapy can be beneficial. Large pseudotumors usually arise from the femur or pelvis. These must invariably be excised, or they will erode through the skin and become secondarily infected with the development of osteomyelitis. Thinning of the cortex can lead to pathological fractures.

Surgery

Surgery in the hemophiliac is now possible and has been carried out. With the advent of total joint replacement, it will be possible now for patients with severe advanced arthropathy to become pain-free and ambulatory. If at all possible, these prostheses should be reserved for the older individual. Synovectomy for prevention of recurring hemorrhages, especially in the knee joints, or removal of chronic hypertrophied synovium, has been carried out. However, its overall or long term efficacy has not yet been determined. The synovectomy should be performed at a relatively early stage before any significant destructive changes have occurred. Other surgical procedures, such as corrective osteotomies for permanent contractures and/or valgus or varus deformities, are also feasible.

With the establishment of hemophilia centers throughout the state, the use of early treatment during the acute stages of hemorrhages, and the advent of reconstructive surgery with the aid of an intensive rehabilitation program, it should now be possible to help the hemophiliac remain productive through the major part of his life. □

trauma

Preventing hand disability from infection

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Despite the availability of antibiotics and improved surgical technique, infections within the hand still irreversibly disable many people. No infection of the hand is too simple to neglect and serious disability may result if treatment is not prompt and proper.[1]

Basic treatment of any infection within the hand includes: 1) Immobilization, 2) Elevation, 3) Warmth (not necessarily moist), 4) Drainage if appropriate, and 5) Antibiotics. Many early infections respond merely to elevation and immobilization substantiating the old adage that "the injured hand must rest."

Cellulitis and lymphangitis, usually following a minor scratch, are most often streptococcal in origin. Septicemia can occur and at times the patient may be gravely ill. Penicillin and erythromycin are specific but elevation and immobilization with warm, moist heat are important adjuncts.

The common paronychia or "runaround" occurs in three stages: 1) cellulitis, 2) an intra- and subdermal abscess and 3) a subungual abscess. The cellulitic phase usually responds to immobilization, periodic soaking, and, if rapidly progressive, antibiotics. The sub- or intradermal abscess must be drained. This can be easily and painlessly done by lying a #11 scalpel blade flat on the nail and insinuating it into the eponychium at the point of maximal swelling. Immediate relief should follow this simple procedure which does not necessitate anesthesia, yet when properly done, it is totally painless to the patient. Again elevation, immobilization, and antibiotics are needed. The subungual abscess presents as a yellowish pocket beneath the nail. Treatment requires ablation of that margin of the nail beneath the eponychium so that it no longer acts as a foreign body. The total nail need seldom be removed and should be preserved as much as possible.

The common felon or distal pulp space infection has three stages also. Early on a cellulitis may follow the minute inciting puncture wound. Immobilization and elevation are usually sufficient for this problem. When a felon becomes established with local abscess formation, throbbing pain substantiates the diagnosis. Treatment entails drainage at the site of "pointing" even if this is on the volar aspect of the pad.[2] The neglected felon progresses to involve the entire volar fat pad producing fat necrosis, skin necrosis, and risking osteomyelitis and tenosynovitis. Drainage of the extensive felon is best accomplished by a liberal incision just beneath the nail distally and extending laterally high on the side of the finger.[3] The volar pad is dissected from the phalanx insuring

This paper was prepared by the department of surgery—plastic surgery division of the Milton S. Hershey Medical Center, Pennsylvania State University, Hershey. The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services assist in the dissemination of information on trauma.

freeing of all the septal compartments. Many of these advanced cases heal with thinned sensitive distal pads tightly adherent to bone, posing a considerable disability to the patient.

The four classic findings of Knavel accurately define the presence of tenosynovitis: 1) there is diffuse symmetrical swelling of the digit, 2) the digit is held in semiflexion, 3) extension is resisted, and 4) there is tenderness along the tendon sheath. If the sensibility of the hand is impaired or a flexor tendon divided, these signs may be absent. At the earliest inception of this problem, conservative therapy with immobilization, elevation, and antibiotics may suffice. If this course is elected, close (hourly) observation of the digit must be made. If rapid improvement is not forthcoming then drainage and irrigation of the tendon sheath should be done. Carter[4] has shown that two linear incisions—one over the middle phalanx and the other over the distal palm—can be used to expose the tendon sheath permitting the insertion of a plastic catheter for continued (48 - 72 hours) irrigation with saline or Bacitracin solution. Two to three days after the catheter is removed, limited motion is started and the wounds are permitted to heal secondarily. A longitudinal incision is recommended because it spares risk to the digital nerves in the swollen hand.

Similar treatment is offered dorsal space infections and the midpalmar and thenar space infections. The direct palmar tenderness and swelling on either the radial side or ulnar side of the third metacarpal facilitates these latter two diagnoses.

An infection within the Parona's space is rare but may result from a neglected radial or ulnar bursal infection. Catheter irrigation subsequent to liberal drainage on the ulnar side of the forearm provides adequate treatment.

Human bite infections, among the most devastating infections of hand, usually occur on the dorsum and follow striking an adversary in the mouth. Penetration into the metacarpal phalangeal joint can occur. These injuries, when seen prior to the onset of infection, should be treated by drainage, antibiotics, immobilization, plus elevation.

Recently the widespread problem of drug addiction has resulted in a variety of upper extremity infections that may mystify the physician. Neviaser[5] has characterized the "puffy hand" of the drug addict and Whitaker and Graham[6] have shown that drainage of these indurated, edematous hand may prove fruitless and that time, elevation, and antibiotics may be the best treatment in many instances.

Infections of the hand can prove disabling unless treated early and appropriately. Although drainage is often needed, elevation and immobilization are equal in importance to the use of antibiotics. Catheter irrigation of infected spaces has proved to be a superior method of treating some of these infections. □

continuing education

This issue carries no education course listings. The January issue contained a supplement—a comprehensive list of education courses being offered in all parts of Pennsylvania. Consult that issue or write for a copy of the supplement to: Pennsylvania Medical Continuing Education Institute, 20 Erford Rd., Lemoyne, PA 17043.

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Emergency Room Physicians—Full time—part time. General hospital serving urban and suburban communities. Experience required. Call or write F. V. Driscoll, Jr., Administrator, Pittsburgh Hospital Div. Forbes Hospital System. 6655 Frankstown Ave., Pittsburgh, Pa. 15206. Telephone (412) 665-3165.

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Physician—Emergency Department, Sewickley, Pa.—Emergency department career oriented physician to work with full time director of emergency department and medical staff starting between March and July 1975. 240 bed modern community hospital with new 5,000 square ft. Emergency Room under construction. 22,000 annual visits. Attractive community 20 miles from University of Pittsburgh. 40-50 hours per week. Benefits include malpractice insurance. Good specialty back-up. Contact: D. W. Spalding, president, Sewickley Valley Hospital, Sewickley, Pa. 15143. Telephone: (412) 741-6600.

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Emergency Room Physician— Excellent opportunity for an experienced ER physician to join on the ground floor of a professional group. This is a 277-bed general, accredited hospital, located in a beautiful suburb of Philadelphia. For further information call or write T. A. Harrington, Administrator, Holy Redeemer Hospital, Meadowbrook, Pennsylvania 19046. Telephone (215) WI7-3000.

Coatesville, Pa. Physicians needed (Family Practice, Internists, Psychiatrists) to work in accredited Veterans Administration Hospital, 38 miles west of Philadelphia. Affiliated with the Jefferson Medical College, Thomas Jefferson University, Philadelphia, Pa. License any state. Salary range $25,581 to $34,788. Commensurate with training and experience. Excellent fringe benefits. Contact Chief of Staff, VA Hospital, Coatesville, Pa. 19320. Nondiscrimination in employment.

House Staff Physician—280-bed accredited hospital seeks Pennsylvania licensed physician for 40 hours per week plus two nights per week. Located in the beautiful suburbs of Philadelphia. $27,500 per year. Call or write T. A. Harrington, Administrator, Holy Redeemer Hospital, Meadowbrook, Pennsylvania 19046. Telephone: (215) WI7-3000.

FP/GP for innovative family health center in north central Pennsylvania. Excellent salary and fringe. Teaching opportunity in F. P. residency. Rural area with convenient cultural and outdoor activities. Contact J. W. Montague, M. D., Medical Director North Penn Family Health Center, Blossburg, Pa. 16912.

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Physician Wanted—family physician—outstanding opportunity for family physician in beautiful rural area approximately 35 miles north of Philadelphia. Well-equipped office and established practice available immediately due to death of former general practitioner.

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Two modern hospitals close by. Write Department 658, Pennsylvania Medicine, 20 Erford Road, Lemoyne, Pa. 17043.

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Internist—32, university trained, board eligible. Available July 1975. Group/Associate/Clinic. Philadelphia and vicinity. Write Box 653, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, Pa. 17043.

Retired Physician, Pennsylvania license, would like full time work in a church related retirement home or similar institution, preferably in Pennsylvania. Write Department 657, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, Pa. 17043

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unique-ly *adv.* - unique-ness *n.*

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Our community offers a safe, comfortable environment with excellent public services and leisure activities. Batesville is located on Interstate 74 among the rolling hills of Southeastern Indiana in close proximity (1 hour) to cultural centers, major medical installations and teaching hospitals in Indianapolis and Cincinnati. It is an area where a physician can practice good medicine as a respected member of the community.

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obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Edward C. Beckley,** West Nanticoke; Hahnemann Medical College, 1935; age 63; died November 25, 1974. Information regarding survivors is not available.

• **David M. Brooks,** Drexel Hill; Jefferson Medical College, 1926; age 71; died July 27, 1974. He is survived by his wife.

• **Herman A. Gailey, Sr.,** York; Johns Hopkins University, 1917; age 83; died December 18, 1974. He served as president of the York Hospital staff for 27 years and was past president of the York County Mental Hygiene Association. He is survived by a son, Herman A. Gailey, Jr., M. D., a sister, and four grandchildren.

• **Max R. Goldman,** Pittsburgh; Jefferson Medical College, 1922; age 76; died November 16, 1974. His wife, a son, Jack Goldman, M. D., and another son, Sherman, survive him.

• **Charles M. Gruber,** Redlands, California; Missouri Washington University, 1921; age 87; died November 19, 1974. He was professor emeritus of the department of pharmacology at Jefferson Medical College. He had been professor and head of the pharmacology department at Jefferson for twenty-one years. Dr. Gruber was a member of the American Physiological Society and American Society for Pharmacology and Experimental Therapeutics where he had served as treasurer, vice president, and president. He was also a past president of the Philadelphia Physiological Society and chairman of the American Medical Association section of Pharmacology and Experimental Therapeutics. He is survived by his wife, a son, a daughter and three stepdaughters.

• **Dewey G. Horine,** Penn Wynne; Jefferson Medical College, 1921; age 76; died November 30, 1974. He practiced medicine for over forty years until his retirement. His wife, a daughter and a sister survive him.

• **Robert G. Lefevre,** Lancaster; Medical College of Virginia, 1925; age 74; died November 5, 1974. He was an instructor for twenty-five years at New York Medical College. Surviving are two nieces.

• **John L. Moyer, III,** Beaver; University of Maryland School of Medicine, 1949; age 50; died November 25, 1974. He was chief of staff and chief pathologist of Ellwood City Hospital. He was a councilor to and fellow of the American Society of Clinical Pathologists and past president of the Pennsylvania Association of Clinical Pathologists and the Beaver County Cancer Society. His widow, two daughters, his parents, and a brother survive him.

• **John J. Sassaman,** Allentown; Hahnemann Medical College, 1938; age 66; died November 29, 1974. There is no available information concerning survivors.

• **Esther Smolens-Cohen,** Philadelphia; Temple University School of Medicine, 1929; age 70; died November 30, 1974. She was acting clinical director of the central unit of the Philadelphia State Hospital and a fellow of the American Psychiatric Association. She is survived by two daughters, one of whom is Marjorie Smolens-Ardon, M. D., three sisters, and two grandchildren.

• **Daniel H. Stouch,** York; Hahnemann Medical College, 1929; age 69; died November 26, 1974. He practiced medicine in York for forty-four years. Surviving him are his wife, his mother, a son, William H. Stouch, M. D., a daughter, and five grandchildren.

• **Joseph R. Sugerman,** Pittsburgh; University of Pittsburgh School of Medicine, 1934; age 65; died December 17, 1974. His wife and two daughters survive him.

Helen M. Angelucci, Fort Lauderdale, Florida; Women's Medical College, 1927; age 78; exact date of death is not known. She was a retired clinical professor of gynecology at the Medical College of Pennsylvania (formerly Women's Medical College). She was a member of the American College of Obstetrics and Gynecology and the American College of Surgeons. Her brother, Venanzio Angelucci, M. D., survives her.

Clayton R. Entwistle, Haverford; Hahnemann Medical College, 1948; age 50; died July 24, 1974. Information regarding survivors is unavailable.

Marilyn Schotland, Wynnewood; Harvard Medical School, 1957; age 42; died July 31, 1974. She is survived by her husband, Donald Schotland, M. D.

David M. Sidlick, Philadelphia; Jefferson Medical College, 1917; age 82; died November 17, 1974. He was a consultant to the AFL-CIO Medical Center and a retired assistant professor of dermatology at the University of Pennsylvania Graduate School of Medicine. He was emeritus dermatologist at St. Mary's Hospital and chief of dermatology at St. Mary's and Einstein Medical Center, northern division. Dr. Sidlick was also the author of articles in international, national, and local publications. He is survived by two sons, one of whom is Leonard Sidlick, M. D.

Putting out the fires of arthritic pain

Rheumatoid arthritis can sometimes spread like wildfire, with joint after joint going up inflamed: "The usual onset is manifested by spotty joint involvement but an acute onset of symmetrical polyarthritis may be noted."*

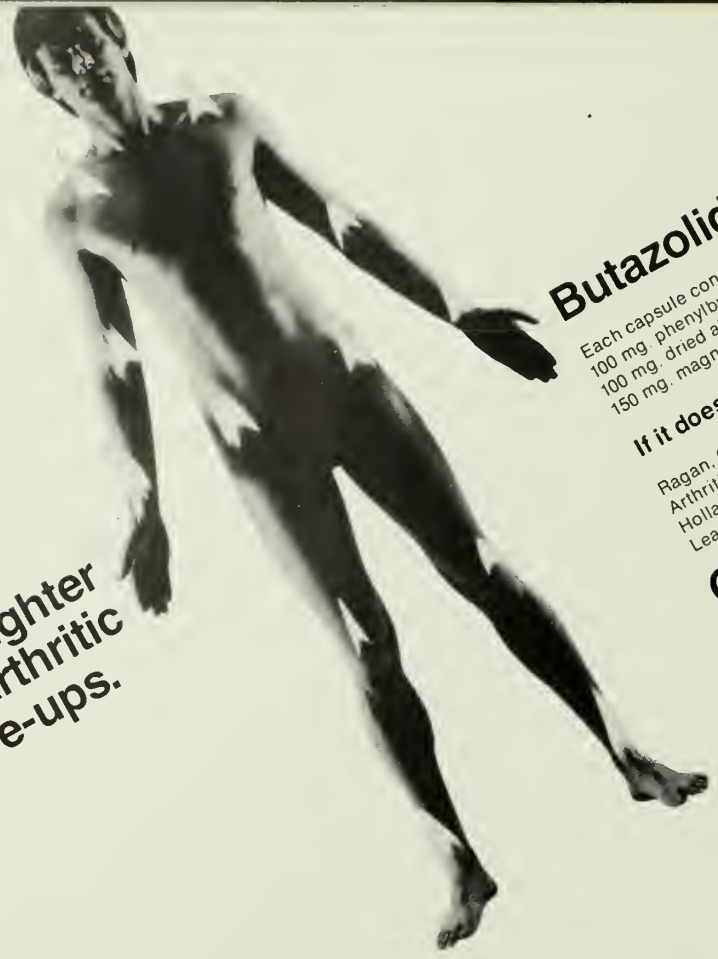
If aspirin fails, consider Butazolidin alka. Giving one capsule four times a day often provides prompt, pain-relieving, anti-inflammatory action to help restore joint mobility. The results you can get within a week can be maintained on as little as one or two capsules daily.

Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions. For full details, please read the prescribing information. It's summarized on the back of this page.

Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.



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Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.

Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Fire fighter for arthritic flare-ups.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction, hypertension; thyroid disease; systemic edema, stomatitis and salivary gland enlargement due to the drug, polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.

(B)98-146-070-J (10/71)

For complete details, including dosage, please see full prescribing information.

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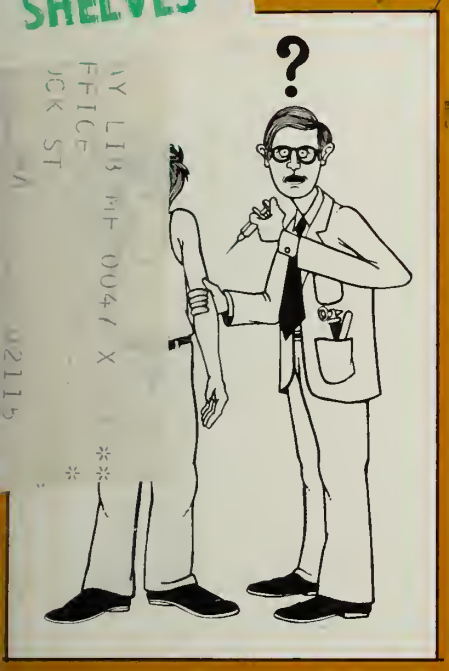

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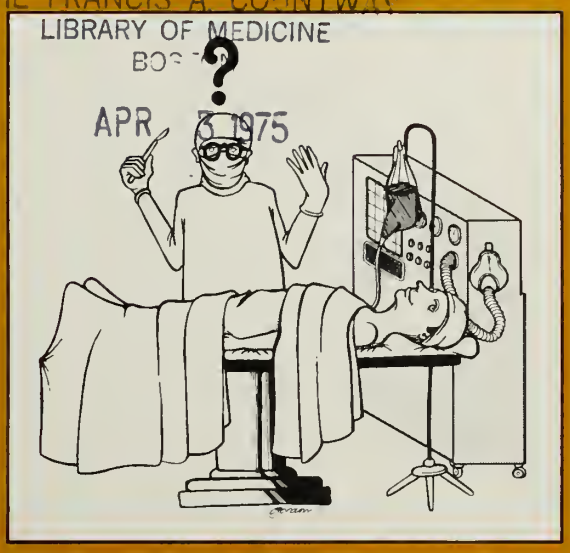

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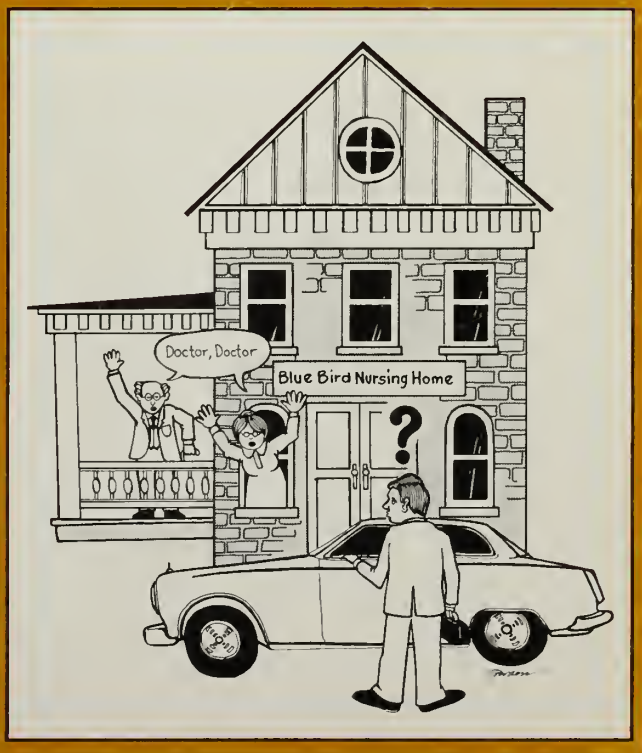

or this covered by medicare? **See page 43**

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pennsylvania medicine

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MALPRACTICE HEARINGS MARCH 18-19 The Insurance Department has set March 18 and 19 as tentative dates for hearings on the malpractice crisis triggered by the rate increase filing of Argonaut Insurance Co. The State Society will offer testimony at the hearings which will be held in Philadelphia. In Harrisburg, both the House of Representatives and the Senate have heard calls for the establishment of select bipartisan committees to investigate the malpractice problem and its impact on the delivery of health care in the Commonwealth. In Washington, Roger O. Egeberg, M.D., special assistant to the HEW assistant secretary for health, said Congress shouldn't try to pass malpractice insurance legislation. He said an understanding of the root problems behind the malpractice insurance crisis is needed before responsible, large-scale action can be taken, and added that federal intervention probably will not be needed. See page 7--the President's Page--for a recount of events in this area.

PENNSYLVANIA AREA IX PSRO IS FIRST The Southcentral Pennsylvania Professional Standards Review Organization (Area IX--covering an eleven county area) is the first planning PSRO in the nation to receive conditional designation from the Department of Health, Education, and Welfare (HEW). James Z. Appel, M.D., Lancaster, past president of the AMA, is chairman of the Board of Directors. The designation becomes final after HEW advertises its intention to change the status from planning to conditional and completes budget arrangements. The eight other area PSROs operating under planning contracts are preparing conditional proposals for early submission. Three others (Areas I, III, and V) have prepared planning proposals. No PSRO structure exists in Area X.

CHP B AGENCIES HOLDING HEARINGS Comprehensive Health Planning B Agencies are scheduling hearings soliciting testimony on the state's comprehensive health plan. So far two have been held, and two more are scheduled--for March 6 in Wilkes-Barre and March 22 in Edinboro. The State Society urges county society officers to participate in the hearings as they are scheduled for their areas. Those interested in the effect the new federal Health Planning Act (P.L. 93-641) will have on health care in the Commonwealth should plan to attend the meeting in their area. See page 10 for further information on the Act.

CHIROPRACTORS FAIL AGAIN The Society's Committee on Quackery was notified in February that the Pennsylvania Department of Transportation issued an order January 28 denying the request of the Pennsylvania Chiropractic Society that chiropractors be authorized to perform physical examinations for drivers license applicants. At hearings conducted late in 1974, Stephen J. Barrett, M.D., committee member, presented testimony for the State Society. Other committee members are: Drs. Leroy A. Gehris, Reading, chairman; John J. Choby, Doylestown; Thaddeus Lekawa, York; Michael P. Levis, Pittsburgh; James A. Raub, Altoona; and John P. Whiteley, York.

DRUG SCHEME REVEALED Joseph V. Morton of the Bureau of Drug Control has issued an emergency warning on a telephone trick being used in some areas of the Commonwealth to obtain drugs. Picking names at random from the telephone directory, callers ask residents the name of their physician and date of their last appointment, explaining that they are conducting a survey. They call the physician claiming to be the patient, say they are ill, and request that a prescription for a drug--in most reported cases Tussionex--be telephoned to a pharmacy, where the counterfeit patient claims it.

COOPERATIVE MEMBERSHIP TOPS 1,800 More than 1,800 State Society members had become charter members of the Pennsylvania Medical Cooperative by January 31, deadline for the charter membership campaign. Recommendations of the Council on Professional Relations and Services regarding continuation of the mass purchasing plan will go to the Society's Board of Trustees at its March 12 meeting. Society members wishing to join the Co-op now must pay a fee of $200.

INCORPORATED PHYSICIANS FACE TAX DILEMMA The question of the amount of assessment of capital stock tax of professional corporations has not yet been resolved by Commonwealth Court, so incorporated physicians have three options again this year. They are: (1) pay in full; (2) pay under protest and indicate that petition for refund will be made if the test case verdict is favorable; or (3) refuse to pay and begin an individual appeal. Physicians who choose not to pay are advised to consult an attorney. The year-old suit which is the State Society's test case is known as Commonwealth Docket 663, 1974. Those choosing option two should refer to this number.

IMMUNIZATION CAMPAIGN PLANNED Letters to the state's family physicians, pediatricians and general practitioners from the Pennsylvania Department of Health will explain requirements of the state's new immunization law so that doctors can answer patients' questions and thereby assist in the public education campaign to educate parents of children entering school in 1975 about the new requirements. The department also plans to assist school districts implement the new law by providing printed guidelines, individual immunization record cards, and informational pamphlets. Because it will take eight months for an unimmunized child to be fully protected, the campaign is beginning immediately. Immunization requirements will be waived for valid medical or religious reasons, the department has announced. The State Society was instrumental in the passage of the immunization law and has cooperated in plans for its implementation.

PHILADELPHIA BLUE CROSS, HOSPITALS STILL AT IMPASSE The thirty-two hospitals which are members of the Delaware Valley Hospital Council and Philadelphia Blue Cross have failed to reach an agreement (other Philadelphia hospitals signed contracts last fall) and were the center of attention for Senator Richard J. Schweiker and Governor Milton J. Shapp at a meeting in Philadelphia February 14. The 24-month old dispute was termed a "crisis" and hospitals were urged to restore services on an interim basis while contract negotiations continue.

Self-employed?
You have a tax break coming to you.

Recent legislation makes an important tax advantage available to self-employed individuals.

You can now put aside up to 15% of your annual income or $7,500 (whichever is less) for retirement—and deduct it from your income for tax purposes.

You won't have to pay taxes on this money, or on the investment earnings, until you retire—at which time your tax bracket should be considerably lower due to your retired status.

To help you get the full benefits under the new law, Pittsburgh National has developed a Master Retirement Plan for the self-employed. You qualify if you're a doctor, lawyer or other professional or operate an unincorporated business, whether or not the business has employees.

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Both often

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in freque and/or severity of grand mal seizures require increased dosage of standard a convulsant medication; abrupt withdra may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous gestion of alcohol and other CNS depre sants. Withdrawal symptoms (similar t those with barbiturates and alcohol) h occurred following abrupt discontinua (convulsions, tremor, abdominal and r cle cramps, vomiting and sweating). K addiction-prone individuals under care

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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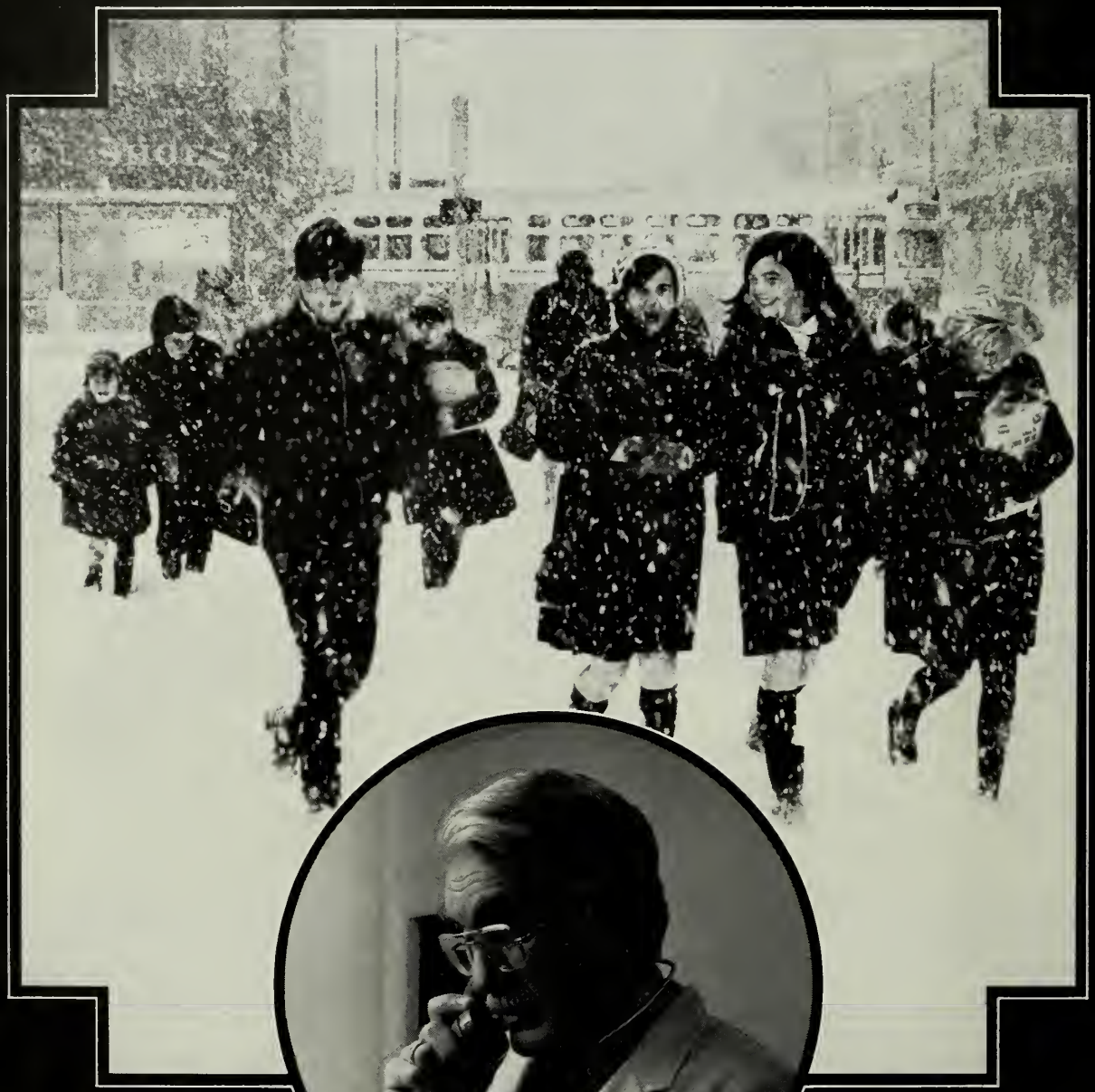

No other nonprescription cough formula is stronger.* 2/G-DM relieves bronchial congestion by making coughing more productive, while it helps stop nagging "dry" cough. 2/G-DM is safe. Its pleasant taste promotes patient acceptance. And since you can recommend it over the phone, 2/G-DM saves *you* time.

*At recommended dose

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Specialists in cough and cold care.

NAS-NRC supports changing antisubstitution laws

The National Academy of Sciences — National Research Council (NAS-NRC) recently released a statement supporting change in state drug antisubstitution laws. During an October meeting the NAS-NRC's Drug Research Board (DRB) passed a resolution changing its position on drug prescribing. The subsequent public statement that pharmacists should be allowed to substitute a brand name drug with a cheaper equivalent drug was released by NAS-NRC on January 22. Of the fifty states, only Florida and Michigan permit substitution.

After passage of the October resolution, the Pharmaceutical Manufacturers Association (PMA) had asked the DRB to reconsider. PMA President C. Joseph Stetler protested then that some board members had misconceptions and differing opinions concerning the resolution. PMA's main objection is that the recent statement is ambiguous and could be construed as an endorsement of compulsory generic prescribing.

The dispute is a result of the Department of Health, Education, and Welfare's maximum allowable cost (MAC) proposed regulations which require physicians to prescribe lowest-cost drugs for medicare and medicaid patients.

The recent resolution is a reversal of DRB's strong support of antisubstitution laws in 1973. Reasons for the reversal include the board's realizing that under the amended laws, a physician would still be allowed to specify brand names. However, he must certify it in writing and be prepared to support his choice if challenged. Also, recent testimony before the Senate monopoly subcommittee has shown that a drug manufacturer can produce one drug and sell it under various names for greatly differing prices. Another reason is the fact that Florida and Michigan have recently passed substitution laws.

In spite of objections by PMA representatives, the DRB concluded that "in the absence of data to the contrary" there is no inherent reason to choose a more expensive drug simply because the name is familiar, and that the pharmacist should then be in the best position to make the substitution if there were a cheaper equivalent to the prescribed drug.

AMA, State Society protest MAC rules

The American Medical Association has filed a formal statement of opposition with the U. S. Food and Drug Administration concerning the proposed maximum allowable cost (MAC) program and is prepared to go to court, if necessary, to block implementation. The State Society endorsed the AMA position in a letter commenting on the MAC regulations from President A. Reynolds Crane, M. D.

The AMA's general objection is that the program is ill-conceived. The MAC regulations "would put the pharmacist between the physician and his patient" if the pharmacist were required to substitute a higher priced brand with a low cost drug, whether the physician approves or not. AMA executive vice president James H. Sammons, M. D., said, "This program very rapidly will have the effect of establishing a national formulary. That would be detrimental to patient care because all patients do not respond to all drugs the same way."

While HEW claims that only bioequivalent drugs will be assigned a MAC, the AMA maintains that it is not possible to assure bioequivalence given present standards. FDA says only about 15 percent of drugs have shown bioequivalence problems. Other experts say that 15 percent includes many commonly prescribed drugs and most antibiotics; so the 15 percent of all drugs could mean as much as 70 percent of all prescriptions.

Another objection to the MAC regulations is that the setting of fees could be a precursor for tighter government control of prescription drugs under National Health Insurance (NHI) and that MAC could be used to open the way for NHI implementation. Dr. Sammons said that "... this will be a limit on the physician's prescribing ability. He will have to limit himself to a very small list of drugs or his patient will end up paying the difference in costs."

The absence of standards assuring uniformity and the decrease in the physician's authority over the drugs dispensed to his patients could increase his malpractice potential and liability, the AMA holds. So far, the status of the physician and provisions for liability under MAC regulations are unclear. It is also unclear what is the physician's liability should a review board decide to overrule his certification for a more expensive drug and have his patient pay the difference.

The AMA submitted its opposition statement before the February 15 deadline for comments on the MAC program. An FDA spokesman says that comments will be considered and that changes in the wording of parts of the regulations are likely to be made.

State Society has new grievance, disciplinary rules

Board of Trustees action taken two years ago brought about House of Delegates action in 1974 mandating new rules on grievances and disciplinary procedures. The changes in procedure occur mainly at the dated new rules on grievance and disciplinary procedures, largely at the county level. The new rules not only spell out the procedure for handling grievances but also assure the person or patient with a legitimate grievance that action will be taken.

The changes affect four main areas: 1. grievance procedures; 2. expulsion from the society; 3. suspension from the society; and 4. investigation of membership application.

Under the new regulations, each county society is required to appoint a county board of censors to handle disciplinary actions concerning members of the society. This board also files an annual report of its disciplinary actions with the State Society. Each county society also has, as a standing committee, a grievance committee.

The purpose of a grievance committee, as defined in the Model Bylaws, is "to prevent or resolve misunderstanding, to clarify and adjust differences between physicians and patients and to assist in maintaining high levels of professional deportment." A formal grievance is a written, signed complaint against a member, received by the county society. Usually patients originate the complaint, although not exclusively. On receiving such a letter, either from the patient or by referral from the State Society, the county secretary forwards it to the grievance committee for consideration.

If the grievance committee, which is empowered to investigate, mediate, arbitrate or refer complaints, handles the situation, the matter goes no further. If, however, within forty-five days, this committee has not given reasonable assurance of handling the matter, the county secretary will send the grievance to the county board of censors. Under an identical timing schedule, a grievance still not dealt with would next be forwarded to the district board of censors who may initiate original proceedings.

In the event of a member's expulsion from the society for disciplinary reasons, the State Board of Medical Education and Licensure and the appropriate hospital medical staffs are notified.

A member of the society who is convicted by a court of a felony or a crime involving moral turpitude will be automatically suspended for an indefinite period. Suspension commences ninety days following conviction. If a member appeals his court conviction, suspension from the society is delayed; if a court reverses his conviction, suspension is nullified. The secretary of the county society is responsible to notify the county board of censors of any member's conviction. The county board next confirms the conviction with the court, then notifies the member of his suspension.

A member may apply for reinstatement no sooner than four months after suspension, with reinstatement occurring no sooner than six months. The member files for reinstatement, writing his reasons why such action should be taken, with the county coard of censors. At a meeting held to consider the request, this board can reinstate a member by a majority vote of members present voting.

Concerning membership applications, each county society will be required to investigate transfer members as well as new members.

Any questions regarding the new rules or their implementation should be directed to State Society Secretary R. Winfield Yarnell, M. D.

THE ANNUAL banquet of the Lycoming County Medical Society was held January 10 at the Lycoming Hotel. In attendance were (left to right): Richard B. Tobias, M. D., county society immediate past president; Matthew M. Mansuy, M. D., vice president; A. Reynolds Crane, M. D., president of PMS; Warren H. Hayes, M. D., county society president; and Sydney E. Sinclair, M. D., vice president-professional relations of Blue Shield.

Hospitals join in effort to explain costs

Ben Badman, Jr.
Chairman of the Board of Trustees
The Hospital Association of Pennsylvania

About a year ago, the Hospital Association of Pennsylvania and the Pennsylvania Medical Society issued a joint communique on the problem of holding down the cost of hospitalization. Co-signed by my predecessor, Milton H. Appleyard, and the late Ralph C. Wilde, M. D., the message stressed that costs are a great concern of hospitals and physicians alike; and it suggested a number of ways hospitals could keep physicians informed of hospital costs.

This type of cooperative venture—and the recent practice of having our respective organizations represented at each other's Board meetings—has impressed upon me, more than ever, the fact that we're all in the same ball game together; and that, while we may have differing points of view at times, we're all working toward the same goal: providing the highest quality health care for our patients at a reasonable cost.

In an effort to help the public better understand what comprises costs for hospitals, institutions throughout the Commonwealth are participating in a Cost Interpretation Program. Initiated by the American Hospital Association, the program is being coordinated by the Hospital Association of Pennsylvania, which also is providing statewide support through the public news media and other more specialized media. But the real in depth work on the program is being done by hospitals at the local level, through newspaper stories, radio and TV interviews, speeches to service clubs, displays, and brochures, to name a few ways.

Although individual hospitals and groupings of hospitals may be on separate timetables throughout the State, the basic outline of the program, and a synopsis of what they're telling the public is as follows:

Personnel: Hospitals are vastly different from other industries: personnel costs account for 60 percent of the budget, rather than 25 or 30 percent, so factors affecting wages and fringe benefits have a greater effect on overall costs. Hospitals are operational 24 hours a day, 365 days a year; they aren't seasonal, and they can't furlough employees just because a particular department isn't busy. They employ an average of three persons for every patient. One employee in three has specialized training, versus one in eight for industry. New specialties (respiratory therapists, CPR technicians, etc.) are being developed. Hospital workers no longer subsidize health care through their own low wages (average earnings were $7,900 in 1973, compared to about $1,800 in 1950).

Equipment: Hospitals are also complex physical plants with sophisticated facilities and equipment, and countless products and supplies. They provide lifesaving devices that weren't even developed 10 to 15 years ago (CCUs, renal dialysis, radioactive isotope diagnosis and therapy, etc.). With a rapidly expanding technology, medical equipment becomes obsolete quickly; and a more sophisticated public, insulated from direct payment of hospital bills by third party payors, is demanding that the most modern facilities be available.

New Services: Hospitals have responded to the rising costs of hospitalization by stepping-up efforts to provide more "vertical" care in expanded outpatient departments, including emergency rooms and specialty clinics. The ratio of outpatient visits to hospital admissions in Pennsylvania's hospitals has increased from six to one in 1968 to eight to one in 1973. More hospitals are providing for outpatient services such as preadmission testing and short term surgery; inpatient services like social work departments, patient care committees, and self care units; and community services like outreach clinics and public education.

Cost Containment: With all of the modernization of facilities and equipment, and the increasing specialization of personnel, hospitals are working aggressively in the area of cost containment through comprehensive health planning activities, group purchasing of food and supplies, modern management engineering techniques, and merged or shared facilities and services. Stepped up utilization review and quality assurance efforts —in which physicians have so vital a role—also are helping to hold down costs; for example, length of stay in the state's short term community hospitals has decreased nearly a full day in the past five years.

Mr. Badman is president and chief executive officer of Wyoming Valley Hospital, Wilkes-Barre.

These are some of the basic elements of Pennsylvania hospitals' efforts to communicate the hospital costs story to the general public.

We need, encourage, and will surely welcome, the assistance of physicians in developing an understanding among their patients as to some of the more significant aspects of hospital costs, and particularly in stressing the importance and value of cost containment programs such as preadmission testing and utilization review—two areas which might directly affect the length of their hospital stay.

I know that, working together, we can achieve our common objective of delivering high quality care to our patients at a reasonable cost—and with a greater understanding on their part.

new members

ALLEGHENY COUNTY:

Mohinder M. Bahl, M. D., 14 Oakwood Terr., Oakmont 15139.
Walter Beh, M. D., 8525 Winchester Dr., Pittsburgh 15237.
Robert R. Buchman, M. D., 2878 Fernwald Rd., Pittsburgh 15217.
Sannasie Chandrasekaran, M. D., 700 Carriage Rd., Apt. 2-A, Pittsburgh 15220.
Douglas M. Dacko, M. D., St. Francis Gen. Hosp., 45th St., Pittsburgh 15201.
George M. Fatula, M. D., Blue Jay Dr., R. D. #1, DuBois 15801.
David Finegold, M. D., 5706 Aylesboro Ave., Pittsburgh 15217.
Elias Y. Hilal, M. D., Mercy Hosp., Locust St., Pittsburgh 15219.
Robert W. Hilberg, M. D., Mercy Hosp., Locust St., Pittsburgh 15219.
Mark May, M. D., c/o Herman Felder, M. D., 3600 Forbes Ave., Pittsburgh 15213.
Charles M. McCool, M. D., 1515 Locust St., Apt. 5-F, Pittsburgh 15219.
Lewis D. Meta, M. D., Mercy Hosp., Locust St., Pittsburgh 15219.
Barry D. Moskowitz, M. D., 3437 Fifth Ave., Apt. 403, Pittsburgh 15213.
Malcolm D. Orr, M. D., 230 Lothrop St., Pittsburgh 15261.
Donald J. Orris, M. D., 1516 Oneida Dr., Clairton 15026.
Carroll P. Osgood, M. D., 9402-Dept. NS, Presby.-Univ. Hosp., Pittsburgh 15261.
Ernest Plaster, M. D., 510 Century Bldg., Pittsburgh 15222.
Jose Ravano, M. D., Pgh. Hosp. Div., 6655 Frankstown Ave., Pittsburgh 15206.
Timothy B. Scarff, M. D., 125 DeSoto St., Pittsburgh 15213.
Carl L. Stanitski, M. D., 200 Meyran Ave., Ste. 320, Pittsburgh 15213.
Alan Stern, M. D., 1515 Locust St., Pittsburgh 15219.
Samuel Tambyraja, M. D., 5326 Pocusset St., Apt. 19, Pittsburgh 15217.
Louis A. Turitto, M. D., 2019 Devonwood Dr., McKeesport 15235.
Edmund C. Watters, M. D., 3 Aspin Court, Pittsburgh 15215.
Bruce L. Wilder, M. D., 151 N. Craig St., Pittsburgh 15213.

BEAVER COUNTY:

Paul V. Rocereto, M. D., 1501 Sixth Ave., Beaver Falls 15010.

BERKS COUNTY:

Suzita N. Granados, M. D., 1555 Schuylkill Ave., Reading 19601.
Leon K. Rittenhouse, M. D., R. D. #1, Box 250, Reading 19607.

CHESTER COUNTY:

John Stuart Willens, M. D., Paoli Mem. Hosp., Paoli 19301.

DAUPHIN COUNTY:

George E. Jefferies, III, M.D., 890 Poplar Church Rd., Camp Hill 17011.
Walter L. Holton, M.D., Box 1502, Milton S. Hershey Medical Center, Hershey 17033.
William B. Iams, M.D., 2247 N. Front St., Harrisburg 17110.
Martin J. O'Neill, Jr., M.D., Milton S. Hershey Medical Center, Pennsylvania State University, Hershey 17033.
Franklin J. Rothermel, M.D., 61 Greenhill Dr., Hummelstown 17036.
Dale P. Svendsen, M.D., Milton S. Hershey Medical Center, Pennsylvania State University, Hershey 17033.

(continued on page 28)

PROLOID® (thyroglobulin)
Caution: Federal law prohibits dispensing without prescription.
Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.
Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.
The ratio of T_4 and T_3 in Proloid (thyroglobulin) is approximately 2.5 to 1.
Proloid (thyroglobulin) is stable when stored at usual room temperature.
Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.
In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.
Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.
Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.
Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.
Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.
Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.
Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.
Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, $T_3{}^{131}I$ resin sponge uptake, $T_3{}^{131}I$ red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.
Instructions for Use. The following conversion table lists the approximate equivalents of other thyroid preparations to Proloid (thyroglobulin) when changing medication from desiccated thyroid, T_4 (sodium levothyroxine), T_3 (sodium liothyronine), or T_4/T_3 (liotrix).

CONVERSION TABLE

Dose of Proloid (thyroglobulin)	Dose of Desiccated Thyroid	Dose of T_4 (sodium levothyroxine)	Dose of T_3 (sodium liothyronine)	Dose of liotrix (T_4/T_3)
1 grain	1 grain	0.1 mg	25 mcg	#1 (60 mcg/15 mcg)
2 grains	2 grains	0.2 mg	50 mcg	#2 (120 mcg/30 mcg)
3 grains	3 grains	0.3 mg	75 mcg	#3 (180 mcg/45 mcg)
4 grains	4 grains	0.4 mg	100 mcg	
5 grains	5 grains	0.5 mg	125 mcg	

In changing from Thyroid USP to Proloid (thyroglobulin), substitute the equivalent dose of Proloid (thyroglobulin). Each patient may still require fine adjustment of dosage because the equivalents are only estimates.
Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.
(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)
Supplied. ¼ grain tablets in bottles of 100 (N 0047-0250-51) and 1000 (N 0047-0250-60); ½ grain tablets in bottles of 100 (N 0047-0251-51) and 1000 (N 0047-0251-60); scored 1 grain tablets in bottles of 100 (N 0047-0252-51) and 1000 (N 0047-0252-60); 1½ grain tablets in bottles of 100 (N 0047-0253-51) and 1000 (N 0047-0253-60); scored 2 grain tablets in bottles of 100 (N 0047-0257-51); 3 grain tablets in bottles of 100 (N 0047-0254-51) and 1000 (N 0047-0254-60); scored 5 grain tablets in bottles of 100 (N 0047-0255-51) and 1000 (N 0047-0255-60). Full information is available on request. P-GP-51 4/c

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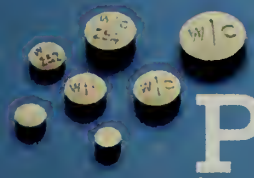
from the rough, uncut stone
to the finished gem



In thyroid therapy, too...
all the qualities of the "natural" with the added improvements of man...

Proloid®
(thyroglobulin)

natural thyroid...but uniquely purified
Devoid of any glandular debris.

natural thyroid...but triply standardized
Standardized chemically, biologically, and (at intervals) clinically, for consistent metabolic activity from batch to batch.

natural thyroid...but consistently fresh
Potency undiminished for up to 4 years under proper storage conditions.

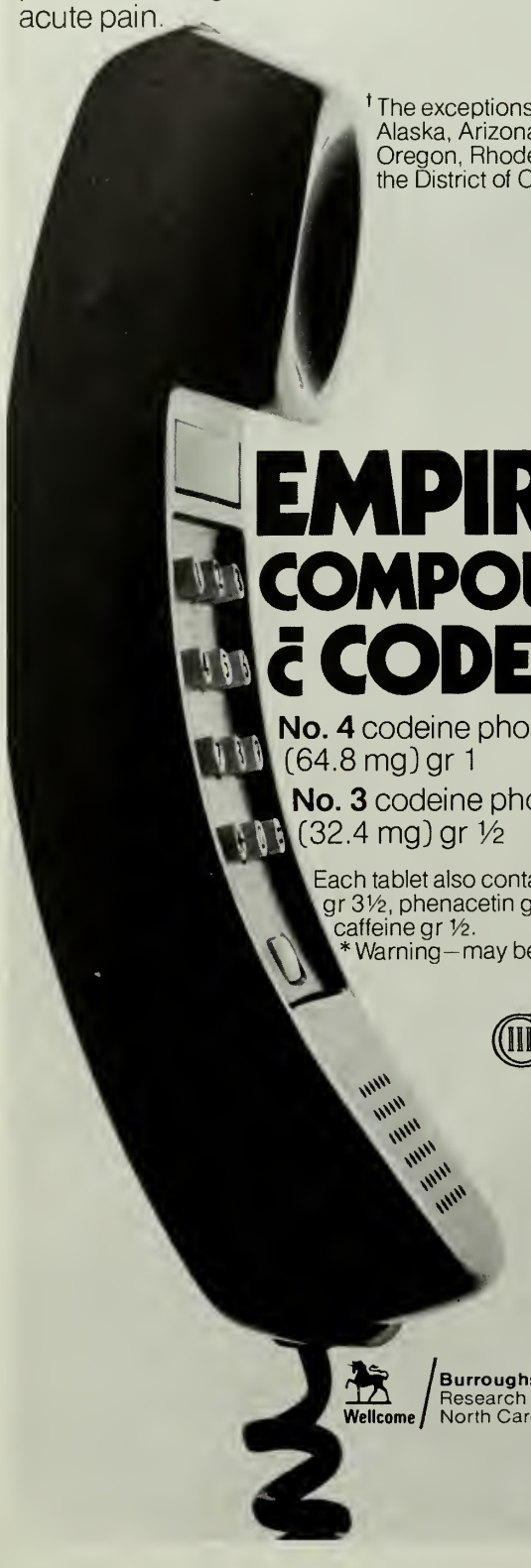
It all adds up to natural thyroid with the added improvements of man.

Please see adjoining column for brief summary of prescribing information.

The Pain Phone

When a telephone prescription for pain relief is necessary or convenient, you can call in your order for Empirin Compound with Codeine in 45 of the 50 states† That includes No. 4, which provides a full grain of codeine for more intense, acute pain.

† The exceptions: Alaska, Arizona, Maine, Oregon, Rhode Island, and the District of Columbia.



EMPIRIN® COMPOUND with CODEINE

No. 4 codeine phosphate* (64.8 mg) gr 1

No. 3 codeine phosphate* (32.4 mg) gr ½

Each tablet also contains aspirin gr 3½, phenacetin gr 2½, caffeine gr ½.

*Warning—may be habit-forming.

Ⓒ III

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IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co.
Medical Department, Box 5110,
Chicago, Illinois 60680

454 R

When diarrhea has his number...

Lomotil puts him back in the game.

Physicians and patients both want prompt control of the symptoms of diarrhea. A rapid, uncontrolled loss of fluids and electrolytes can cause a medical crisis, particularly in children, and in patients who are seriously ill, or in people who are badly undernourished.

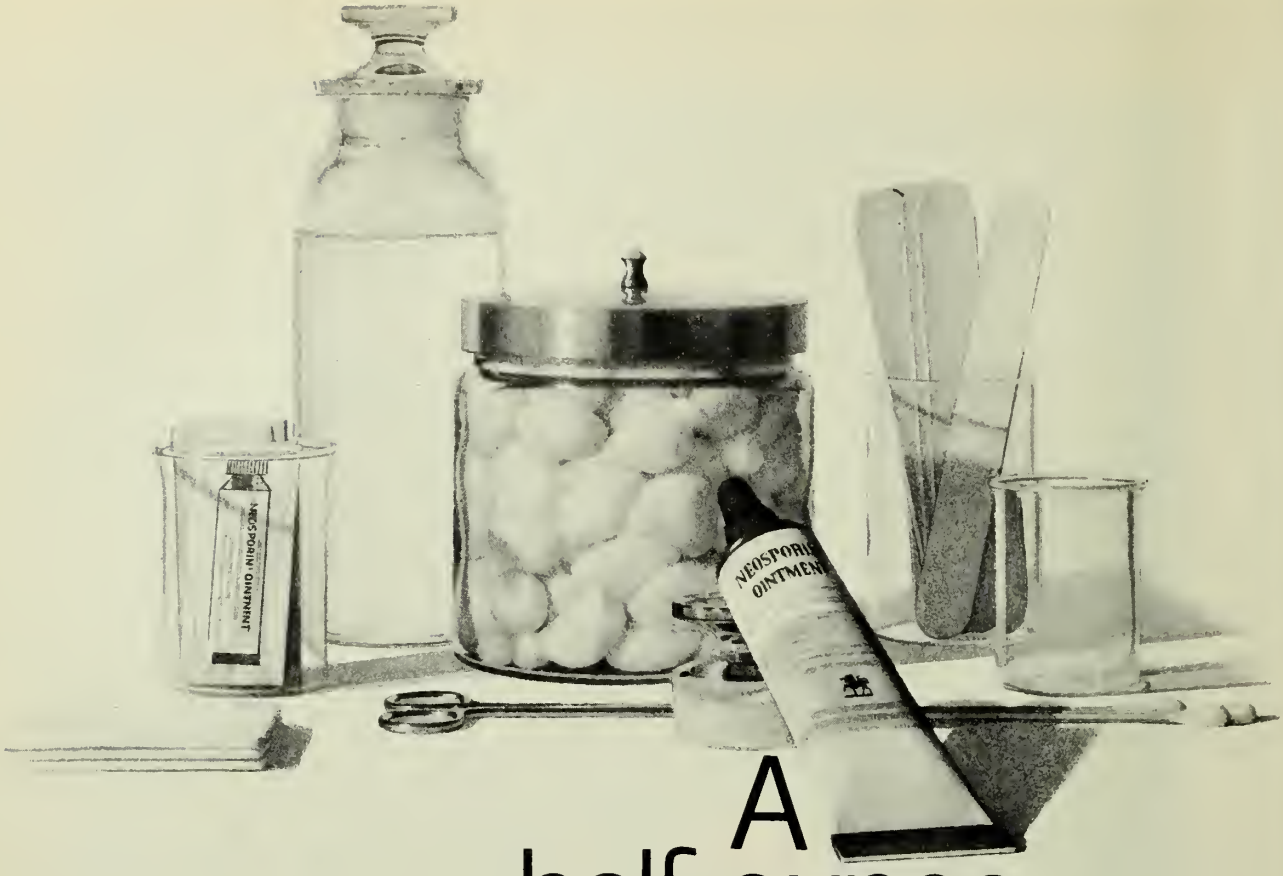
Lomotil usually stops diarrhea promptly. This rapid action halts the emergency aspect of diarrhea and is comforting and reassuring to the patient. Electrolyte and fluid losses can be corrected while the specific cause of the diarrhea is being determined. If an infective agent is the cause, appropriate antibiotic therapy should be given along with Lomotil.

Lomotil has few side effects, and those that do occur are generally mild.

Lomotil®
TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride ..... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate ..... 0.025 mg.

Usually stops diarrhea promptly.



A half-ounce of prevention

Use it to prevent a topical infection. Or to treat one that's already started. In either case, it's good medicine. Whether for lacerations, burns, open wounds, IV catheter or surgical aftercare. Neosporin® Ointment provides broad antibacterial coverage against common susceptible pathogens. And since it contains three antibiotics that are rarely used systemically, the risk of sensitization is reduced. Neosporin Ointment. A half-ounce of prevention. Also available in a full ounce of prevention and in convenient foil packets.

Neosporin Ointment carried on Apollo and Skylab missions.

Neosporin® Ointment
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs.
In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: *Therapeutically,* used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.
Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of perso allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PM

Wellcome / **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F CO.
Carolina, P.R. 00630
Subsidiary of
SmithKline Corporation

KEEP THE HYPERTENSIVE PATIENT ON THERAPY KEEP THERAPY SIMPLE WITH DYAZIDE®

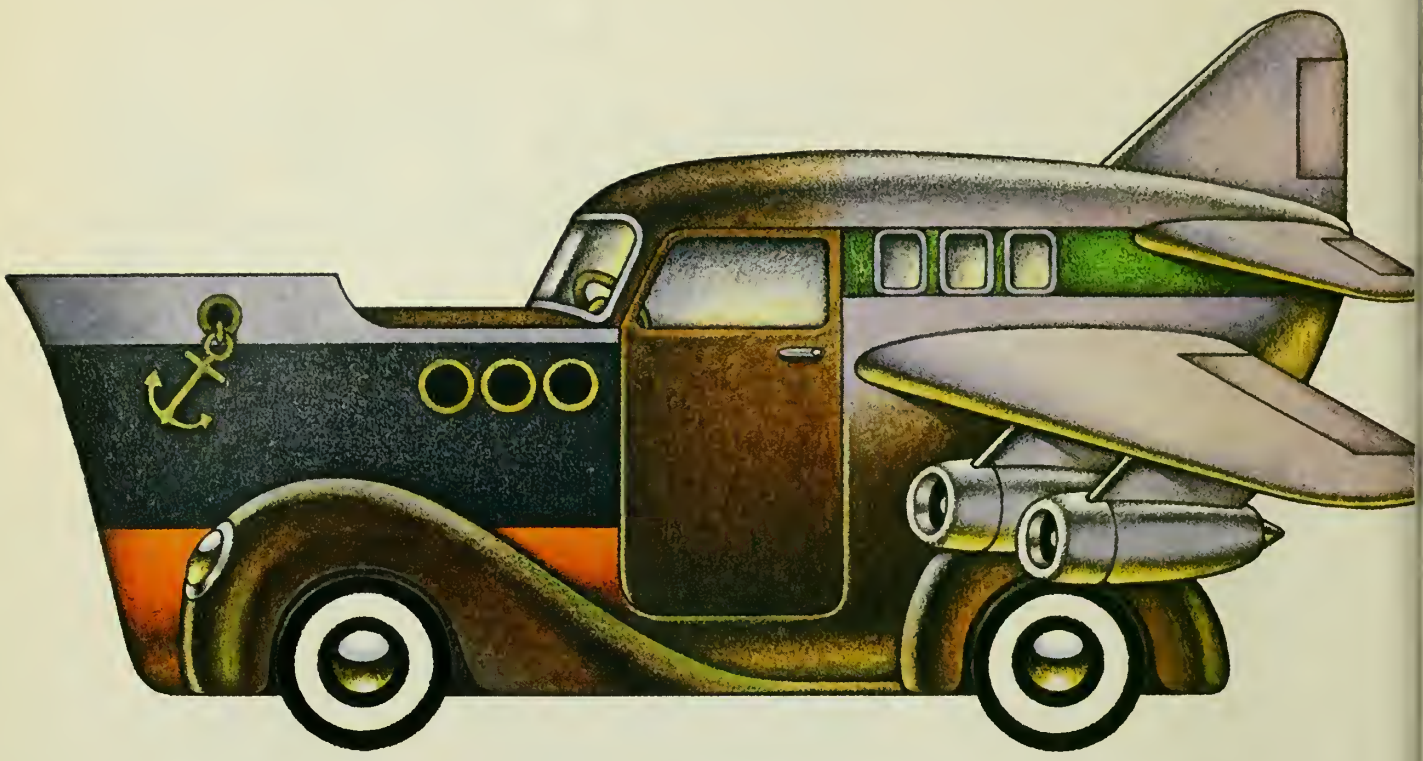
Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Neither inconvenient potassium supplements nor special K^+ rich diets needed as a rule. Just 'Dyazide' once or twice daily for maintenance.

Two prime reasons patients drop out of hypertensive therapy are (1) the patient failed to understand directions, and (2) the regimen was overly complicated. Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

TO KEEP BLOOD PRESSURE DOWN AND KEEP POTASSIUM LEVELS UP



On land, sea, and in the air...

Up to 24 hours of effective control with a single dose...in nausea, vomiting and dizziness associated with motion sickness.

Dosage: 25 to 50 mg. 1 hour before travel.
Available on prescription only.

BRIEF SUMMARY OF PRESCRIBING INFORMATION
CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

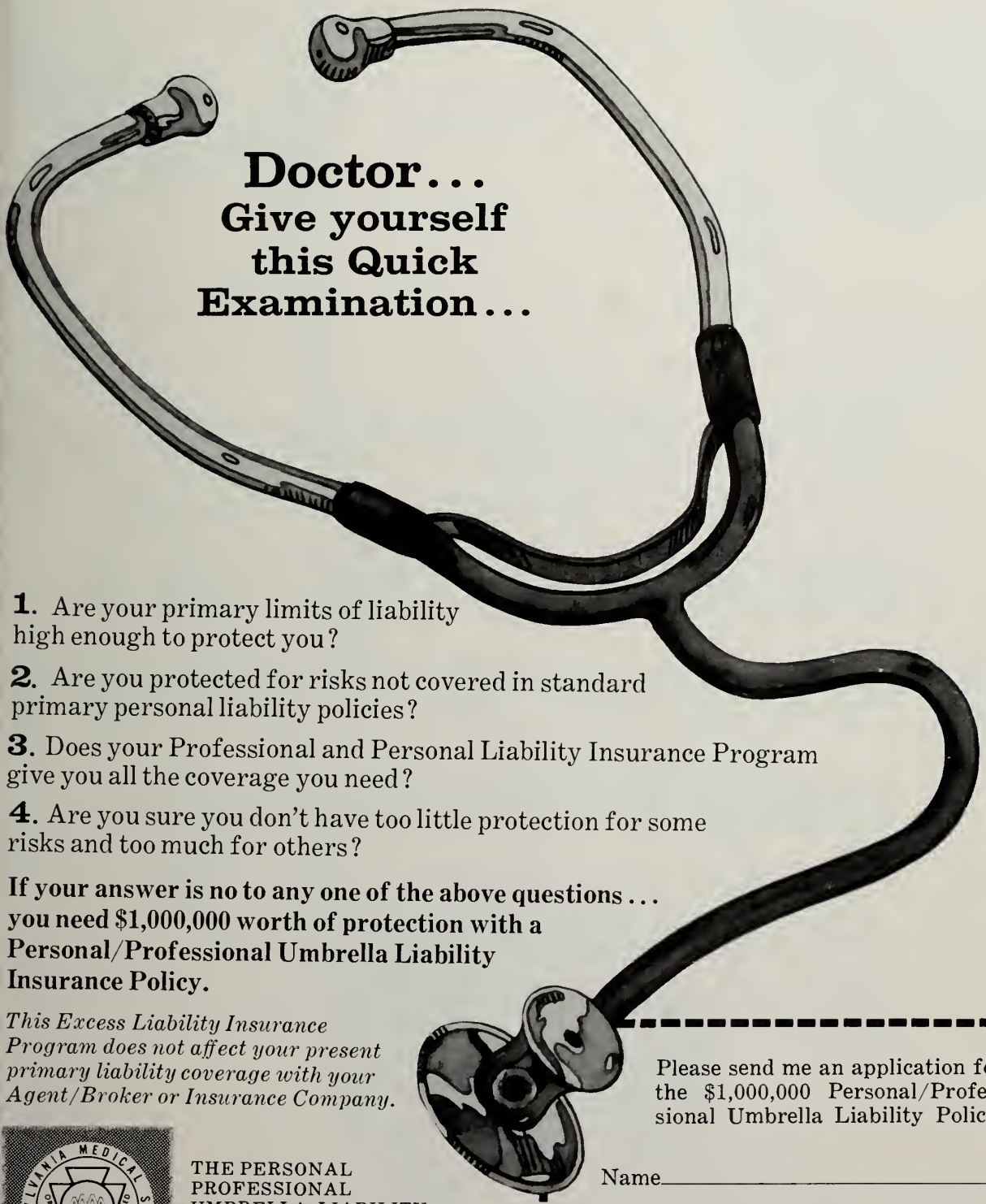
Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25 Chewable Tablets
(meclizine HCl) 25 mg.

for motion sickness



Doctor...
Give yourself this Quick Examination...

1. Are your primary limits of liability high enough to protect you?

2. Are you protected for risks not covered in standard primary personal liability policies?

3. Does your Professional and Personal Liability Insurance Program give you all the coverage you need?

4. Are you sure you don't have too little protection for some risks and too much for others?

If your answer is no to any one of the above questions... you need $1,000,000 worth of protection with a Personal/Professional Umbrella Liability Insurance Policy.

This Excess Liability Insurance Program does not affect your present primary liability coverage with your Agent/Broker or Insurance Company.

THE PERSONAL PROFESSIONAL UMBRELLA LIABILITY INSURANCE PROGRAM HAS BEEN ENDORSED BY THE PENNSYLVANIA MEDICAL SOCIETY

ADMINISTRATOR

ALEXANDER AGENCY INC.

INSURANCE WORLD-WIDE SINCE 1853
Union Bank Building, Pittsburgh, PA. 15222

Please send me an application for the $1,000,000 Personal/Professional Umbrella Liability Policy.

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Office Address_____

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State_____ Zip_____

Telephone_____

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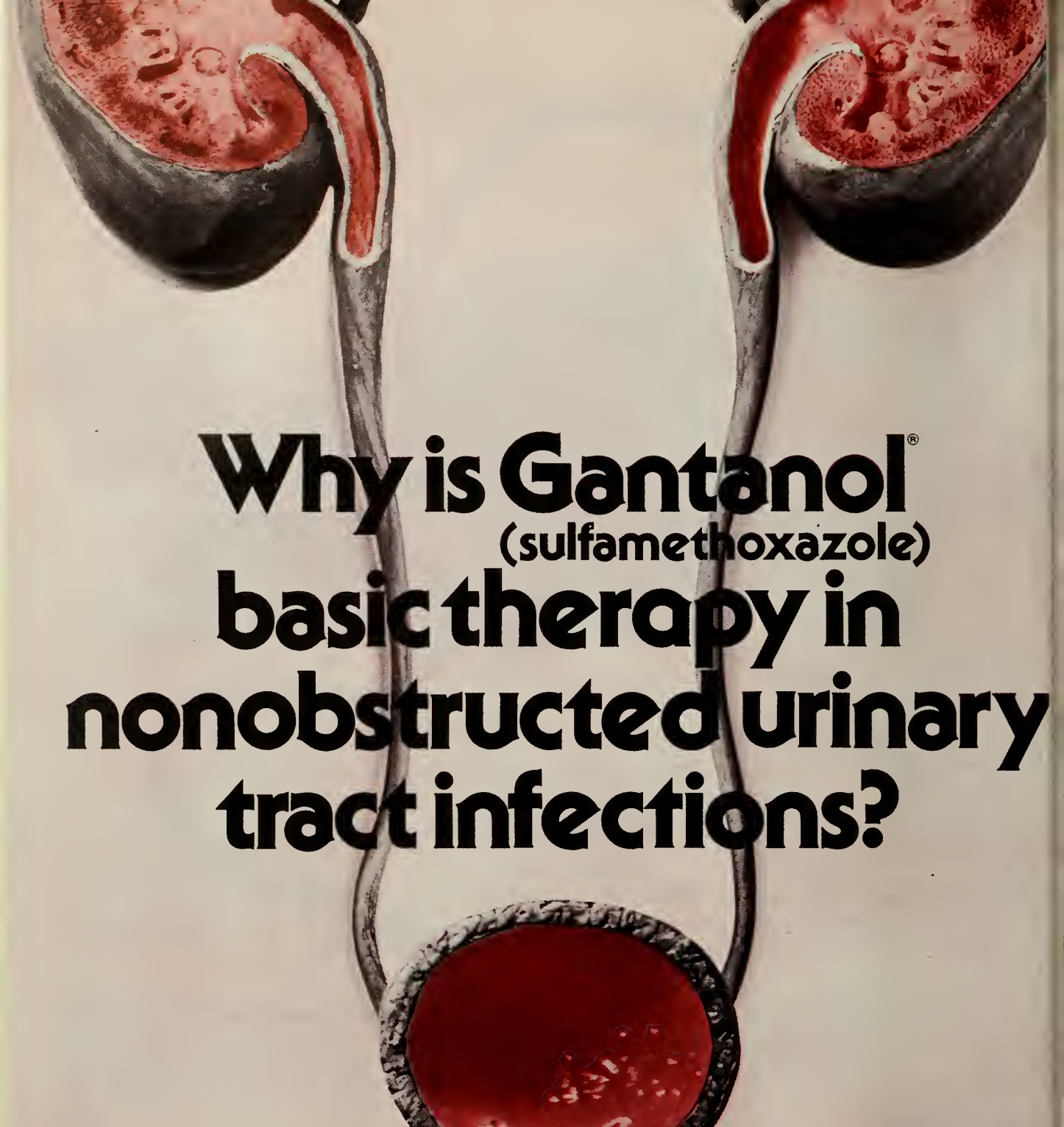
Union Bank Building, Pittsburgh, PA. 15222



Why is Gantanol® (sulfamethoxazole) basic therapy in nonobstructed urinary tract infections?

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pur-

Because it is considered a good choice...

- for efficacy in nonobstructed cystitis, pyelonephritis and pyelitis
- for control of susceptible *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*
- for prompt antibacterial blood and urine levels in from 2 to 3 hours after initial 2-gram adult dose
- for economical around-the-clock coverage
- for maximum patient cooperation with easy-to-remember B.I.D. dosage

Basic Therapy

Gantanol®

(sulfamethoxazole)

Tablets/Suspension
(0.5 Gm) (0.5 Gm/teasp.)

pura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis): *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

When **impotence** *due to*

androgenic deficiency

is driving them apart

Android®-5 MUQETS BUCCAL Tabs

Android®-10 ORAL Tabs

Android®-25 ORAL Tabs

Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**

2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

COLD FEET
LEG CRAMPS
TINNITUS
DISCOMFORT ON STANDING

LIPO-NICIN®

gives you a choice for

IMMEDIATE or GRADUAL

nicotinic acid therapy

IMMEDIATE RELEASE		GRADUAL RELEASE
LIPO-NICIN/100 mg. Each blue tablet contains: Nicotinic Acid .....100 mg. Niacinamide ..... 75 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 5 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000	**LIPO-NICIN/250 mg.** Each yellow tablet contains: Nicotinic Acid .....250 mg. Niacinamide ..... 75 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 3 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000	**LIPO-NICIN/300 mg.** Each timed-release capsule contains: Nicotinic Acid .....300 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 3 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

WRITE FOR LITERATURE AND SAMPLES

BROWN **THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th St., Los Angeles, CA 90057**

REFER TO PDR

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Mead Johnson LABORATORIES

the original triple antigen

RHUS-ALL

NOW IS THE TIME TO PROTECT YOUR PATIENTS FROM SEVERE REACTIONS TO

POISON IVY OAK and SUMAC

RHUS-ALL is an effective prophylactic against these three common summer irritants. Usual dosage consists of 2 - 3 injections intramuscularly, at weekly intervals, prior to exposure.

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new members

(continued from page 16)

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practice management

What a doctor can do to help his estate planning

LEIF C. BECK, LI.B. and
VASILIOS J. KALOGREDIS, J.D.
Bala Cynwyd

Physicians will in many cases have little involvement with estate planning except to know at some time in life that it needs some attention. That may in turn result in contact with an attorney and the resultant drafting of a will for the doctor involved and his wife. We believe that each doctor should take a more active role in planning his own estate, and the following comments will hopefully describe areas in which the proper input from the physician is crucial to his and his family's financial future.

Complete inventory of your estate

The first concern in the process is precisely what the doctor's assets and liabilities presently are, a matter with which advisors themselves tend sometimes to be overly casual. A complete inventory marshals the facts so an informed expert judgment can be made by an attorney and other advisors both as to whether an existing estate plan is still sound and whether additional steps should be taken. In either case, of course, the advisors' purpose should be to help the doctor utilize his assets and income to realize his financial objectives most effectively.

A well-developed inventory has many additional planning values. First, it will provide the data required to project the probable growth of the doctor's estate over the next few years. Secondly, it can be very helpful to tax advisors in determining how tax liabilities against one's income and estate may be minimized. It is also essential in estimating the income production that can be expected from one's assets in retirement or for the family after death. Finally, a doctor might, through reviewing his present estate status, measure his future needs and consider methods of bridging any gaps between future income and future needs. None of these goals can, however, be accomplished without complete and accurate information accumulated or "inventoried" by the physician himself.

Inventory of present net worth—Complete listing of a family's assets and liabilities should follow a certain routine. For instance, besides listing the present value of the assets, the doctor should also list the original cost of each asset. This is relevant since decisions of making gifts during life as opposed to holding certain assets until death will turn in part on whether substantial capital gains or losses are inherent in each asset under consideration.

The list of items comprising one's net worth would contain the following assets:

- Cash
- Notes Receivable
- Bonds
- Stocks
- Mutual Fund Shares
- Real Estate
- Life Insurance (copies of policies, face values, cash surrender values, payer of premiums, loans outstanding): (a) on own life, whether owned by the doctor, his wife or others; (b) on others lives, but owned by physician
- Employee Benefit Plans (where possible providing copies of plans, listing when participation began, amount vested, retirement benefits, and death benefits): (a) pension (b) profit-sharing (c) Keogh (d) deferred compensation (e) group insurance
- Accident, Health and Medical insurances
- Business Interests: (a) medical practice (b) realty interests
- Miscellaneous Personal Effects: (a) home furnishings (b) automobiles (c) boats (d) jewelry (e) collections (f) furs (g) patents

It is obviously important also to indicate who owns each asset: the husband, his wife, or both. Without this knowledge, the estate planning can lead to disastrously costly mistakes, although we have too often seen the identification overlooked when not originally made available.

The physician's listing of liabilities should include:

- Real Estate Mortgages: (a) home (b) others
- Personal Loans: (a) from banks (b) from individuals (c) from insurance companies
- Contingent Liabilities: (a) pending practice related legal actions against the doctor; (b) pending non-practice related legal actions against the doctor and/or his immediate family
- Miscellaneous debts or possible problems

The physician should indicate those debts which are his alone, those he shares with others (sharing primary responsibility) and those he has cosigned (with only secondary responsibility, another person being primarily responsible).

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd, Pennsylvania.

Analysis of present income and expenses—The doctor should also develop a reliable analysis of his family's annual income and expenses. From this information, a reasonable projection of his family's future income and future income needs at retirement and at death can be made. That future income would include moneys from annuities, contracts, insurance policies, Social Security rights and pension and profit sharing plan participations as well as the principal and income from investments he accumulates.

Objectives

Relevant to any successful estate plan, of course, are the doctor's and his family's objectives. There are many important questions which a doctor should consider before and during meetings with his estate advisor, and our breaking them down into the several categories described below may be helpful in framing his objectives.

At the doctor's death or disability:

- What are his spouse's minimum income requirements?
- How much would he want to provide for her and for his children?
- Will the wife continue to live in the present home?
- Should the home mortgage be paid off?
- How capable is the wife of managing financial affairs?
- What Social Security benefits are available for the wife and children?
- Should she be protected against: (a) capriciousness? (b) possible second husband? (c) senility? (d) anything else?

Retirement:

- At what age does he wish to retire?
- What minimum income will be required?
- How much can corporate pension and profit-sharing plans, Keogh plans, Social Security, annuities, and other retirement-oriented programs be expected to provide upon retirement?
- Will the programs above *alone* allow a doctor to retire and live in a way that will be palatable to him?
- Does he expect to retire from private practice at a certain age, while continuing on in educational, governmental, administrative or other medically related income-producing pursuits?
- What does the doctor anticipate realizing upon his practice at retirement? Would the accounts receivable inure to his benefit? What will they be worth? Can the office building, equipment or other practice values be sold?
- In a group practice (of two or more doctors) what income continuity or other payments are called for at retirement? Do the practice documents provide for fair and equitable payouts?
- If there is any business involvement ancillary to the medical practice (such a practice-related real estate partnership), what, if anything, do its documents provide upon retirement?
- What is the doctor's investment philosophy? Does it stress growth, income or preservation? Does he have the same attitudes when dealing with his personal investments as opposed to his corporate retirement and Keogh plan monies?

Children:

- What are the doctor's hopes for them?
- What appear to be their capabilities?
- Who should have custody of the minor children and their property if both parents should die?
- Should the children be permitted to freely use any funds left to or for them, or should they be restricted to the income from those funds?
- When and how should any funds held in trust be paid over to the children?
- Should any special problems be considered and special allowances made for physical defects, personality or ability deficiencies on the one hand *or* superior ability or potential on the other? Examples would range from a child needing ongoing expensive medical care to one with the apparent potential for expensive medical school attendance.

Contingent beneficiaries—If the doctor's wife and children do not survive him, who would he want as beneficiaries under his will and any trusts involved?

The above listing is by no means all-inclusive. However, it includes the types of decisions which a doctor himself must make sooner or later, and a lawyer's office is no place for the lengthy deliberations involved in making these choices. An estate advisor can help institute the best steps for one's estate *from a purely financial and tax point of view*. But without the input which the doctor can provide after some deliberation as to his objectives, even the best estate planner in the world could not guarantee the best estate plan for an individual *from all points of view*.

Implementing common, important objectives

Fully providing for dependents at minimum tax cost—Most physicians agree that the comfort of their wives and minor children is their prime concern. Their second goal is that whatever remains passes on to their adult children with the least possible loss due to taxes. They may, however, simply feel that by leaving all of their estates outright to wives they will satisfy these purposes. Unfortunately, this often will be the least desirable way of accomplishing those goals, especially since a similar result can be achieved by other means.

An oversimplified example might illustrate the situation. Dr. A, with an estate of $620,000 wills it all to Mrs. A. Upon his death, his estate gets a "marital deduction" of $310,000 (½ of his estate) and a $60,000 exemption. As a result, a gross federal estate tax of $65,700 would be paid on the remaining taxable estate of $250,000. Mrs. A dies thereafter, (having had little or no estate of her own) leaving her children an estate of $560,000, which is everything remaining from her husband's es-

tate after the tax and some income therefrom. Since she had no spouse to will to, her estate would not have the advantage of the "marital deduction." Her estate still gets the $60,000 exemption, leaving a $500,000 taxable estate. The gross federal estate tax thereon would be $145,700. As a result of these two deaths, an estate of $620,000 would have dwindled to $408,600.

On the other hand, assume that Dr. P also had a $620,000 estate and also wanted to most fully provide for his wife and children. His will, however, provided that one-half of his estate would go outright to his wife while the other half would be placed in trust with Mrs. P entitled to its income for her life. The trustee was further directed in writing to use the trust's principal for Mrs. P's benefit whenever necessary for her "health, support, or maintenance" (special words since the estate tax results may fail if the appropriate language is not used). The principal would ultimately be paid over to the children after Mrs. P's death. By creating this estate plan, Dr. P would have kept half of his estate from being included in Mrs. P's estate upon her later death. The reason is essentially that this half in trust for her is *not really hers* within estate tax rules.

The estate tax figures for Dr. P's situation are as follows. On his death his estate would pay the same $65,700 in gross federal estate tax that Dr. A did. The dramatic difference between the two estate plans would, however, result upon his wife's later death. Her estate would only be $230,000 for tax purposes—one-half of what Mrs. A's had been, Mrs. P having received only half of her husband's estate directly. After deducting the $60,000 exemption upon her death, her estate would have to pay gross federal estate tax of $41,700. The total federal estate tax paid upon Dr. and Mrs. P's deaths would thus have been only $107,400 as opposed to the A's $211,400—*a dramatic $104,000 savings.*

The larger the estate, the more dramatic the savings if a plan such as Dr. P's is instituted. It works mathematically, of course, on even smaller estates, but we believe there is a practical limit below which the device is not worthwhile. At an estate of $180,000, or less, we think the 50 percent marital deduction, the $60,000 tax exemption and the trust's costs and administrative burdens would eat up the tax advantage.

How to protect minor children and their property— The wills of parents having minor children should provide for those children's care in case both parents die before the children have legally become "adults." There are two aspects of a minor's guardianship: (a) who is to have personal control ("custody") of the child, and (b) who is to manage the child's property.

Great care must be taken in the selection of the guardian of the person of a minor. This guardian should be the individual or couple who is or are considered best suited to serve as "substitute parent" for the children. He and/or she must be willing to accept the responsibility and thus should be consulted before being designated. The designation should be reviewed at regular intervals to assure that it is still appropriate, for death, illness, changed personal relations and many other factors might intervene.

The selection of the guardian of the property is a different matter. In most cases, the nature and extent of this person's responsibilities are such that a degree of professional competence is desirable and necessary. For example, failure to act quickly on a claim for damages due to the child's parent's death by accident may result in a substantial loss to the minor. In spite of the best of intentions, an unskilled guardian might not be able to act quickly enough. The guardian of the property also personally runs the risk of having to make up any losses out of his own pocket since the law imposes a "fiduciary duty" upon him.

Where the guardianship may continue for some time or where substantial property is involved, a bank is often the better choice. Furthermore, in many cases it is preferable to minimize the guardian's involvement by passing as much of one's estate as possible into a formal trust or trusts.

Who should manage the estate?—Completing a sound estate plan involves more than just maximizing the moneys and other net assets becoming available to the beneficiaries. A sound selection must also be made as to who will manage and execute the plan.

Too often, executors and trustees are selected without the proper concern for the ability and responsibility necessary in carrying out an estate plan. A physician should realize that his selection of an executor and/or trustee is equivalent to his selecting someone to step into his shoes in managing the family finances. He should fully appreciate the high standard of integrity, experience, ability, and understanding to be sought, not only in that substutute but also in his (or its) successors.

The question thus becomes whether an individual or a corporate (e.g. bank) fiduciary should be named. The most compelling reason for naming an individual fiduciary is the feeling that a particular individual has special knowledge, experience, familiarity, and understanding of the personalities, preferences, and problems of the physician as well as his family and business undertakings.

Not all individuals, however, have the experience or ability to carry out the many complicated and technical chores required of an executor or trustee. Furthermore, a person considered well qualified to serve such a capacity might change in personality or competence as he ages, possibly to the detriment of the original trust placed in him. As a result, choosing one family member as executor and/or trustee carries some degree of risk.

In many instances the ideal arrangement is for an individual conversant with the physician's family, practice and other business involvements to serve as co-executor and co-trustee with a bank. This would provide for the personal and human elements which are material factors in any estate situation, while the bank's involvement would relieve the individual fiduciary from the administrative burdens and the responsibilities of the job. It would also insure continuity and permanence

of representation which is essential to properly carry out the complete testamentary scheme of the testator.

Have all contingencies been covered?—If a physician's wife and children do not survive him, who should the beneficiaries be? State law answers this question if the will does not expressly provide for contingent beneficiaries. Most doctors would surely prefer that the benefits of their estates pass to contingent beneficiaries of their own choosing, rather than as dictated in the law books. And even if a doctor thinks state law would conform to his wishes on this question, it would be far better for his will to state those instructions than to depend on "operation of law."

The selection of contingent beneficiaries is often more difficult than choosing primary beneficiaries. The lawyer's office is not the place for such lengthy deliberations. Much thought should be given to this question before meeting with him.

Some couples may find there are no contingent beneficiaries to whom they wish to leave their estate. In such circumstances, a physician should not overlook his schools, hospitals, churches and favorite charities. There is an added advantage to such bequests. Since the Internal Revenue Code allows an estate tax deduction for amounts passing to charity, less of one's estate will be taxed and more will be available for the charitable uses if the situation of contingent bequests actually arises.

Conclusion

The estate planning area is a very complex one, and this article is in no way intended to be all-inclusive. In fact, it just barely scratches the surface. When considering his estate situation, a physician must remember that "no man's judgment is better than his information." No matter how technically expert one's estate planning advisor may be, he cannot be really useful without accurate and thoughtfully considered input from the physician himself.

editorials

Diagnostic workup on AMA

The American Medical Association's financial reserves have declined from more than $10 million in 1969 to minus $1.8 million in November 1974.

The AMA considered significant cutbacks in journal publications, specifically, *JAMA* from 52 to 48 issues per year, specialty journals from one per month to quarterly, and elimination of *Prism*.

The AMA's Board of Trustees recommended that advertising in association publications be discontinued.

The Board also recommended the elimination of five councils and twenty-nine committees.

And finally, a $90 dues raise was recommended.

These recommendations were presented to the House of Delegates at the Twenty-eighth Clinical Convention in Portland, Oregon, last November. It is an unfortunate revelation that our national organization finds itself in a serious financial crisis. Although a certain amount of the fiscal difficulty can be attributed to inflation, individuals, businesses, and organizations are all affected in a relatively like manner by the economy. As physicians, we fared worse than most because of the restrictions governing our fees, but, while our net income is shrinking in comparison to the rest of the economy, we have managed to meet an increasing overhead. If the AMA has economized on telephones, copy machines, postage, employee overtime, paper quality, travel expenses and reduction in staff by attrition, it has done no more than the average American physician.

The second, and more significant, possibility is that of poor executive management. The way in which delegates met and disposed of the Board's recommendations indicates a desire to explore the AMA's finances in greater depth. A committee of the House was appointed for this purpose and instructed to report back at the Annual Meeting in June 1975.

A $60 assessment was passed in lieu of the recommended $90 dues increase, from 110 to 200. Several delegations expressed concern that the states would challenge unified membership if dues were increased. Should members decide to bolt the AMA as New York did in 1971, the resultant loss of revenue would render the net gain minimal. With skyrocketing malpractice premiums, high overhead, and inflation, the additional burden of increased dues on individual physicians is certainly not a welcome thought.

Wholesale slashing of journal publication at a time when so much emphasis is being placed on medical advancement and education is not a sensible solution. Better management is. Attractive covers are nice but prohibitively expensive. Advertising in AMA journals has been supported and attacked on both financial and ethical grounds. The special committee will have to decide whether

drug advertising helps to defray publication costs or is a potential tax liability. Most careful consideration will have to be given these twin problems so that both educational and financial interests are served.

Physicians need a national organization. A loose confederation of state societies with no national voice or aim cannot hope to cover the gamut of medical interests and legislation that the AMA has. If the AMA were to die, then another group would, of necessity, have to fill the void. The $60 assessment is the best solution at this time. But the assessment alone is not enough, for at the current spending rate, it will be gobbled up in short order. Should the special committee report in June that a dues raise is definitely justifiable, then to save our organization, we will have no option but to approve it. Organized medicine at the national level will have to tighten its belt, but it cannot be allowed to wither at this crucial time in history for lack of a justifiable dues increase.

David A. Smith, M. D.
Medical Editor

Disposable or reusable surgical drapes—a spurious controversy

Twenty-three years ago I called attention to the inefficiency of the usual textile materials used as surgical drapes.[1] They would serve as a barrier to contamination if they remained dry, but would actually pull microorganisms through them by a wicking action when in contact with any contaminated liquid such as water, sweat, amnionic fluid, or blood. Only dry drapes are aseptic barriers.

Ten years later I reported that I had been shown a material which resisted the transmission of water and was therefore acceptable as a barrier drape.[2] This material was a nonwoven material intended for single use. I classified it in my own mind as a paper material, and strongly advised its use.

With these two published observations there have grown some *incorrect* conclusions.

It is true that the textile materials on which I originally reported were hydrophilic, or loved water and spread contaminating microorganisms like a blotter. It is, however, *not* true that *all* woven materials soak up water. Some are so closely woven and are treated by special waterproofing agents enabling them to resist the passage of water and be effective barriers—even with repeated laundering.

Some of the nonwoven materials, in contrast to the one I first tested are *not* resistant to the passage of water. They can be just as ineffective a barrier as the cloth ones which proved so poor.

We should use an effective barrier material which is resistant to the passage of water. How waterproof does it have to be? Is there a way one can tell, or is there a test which one can require as a standard?

There is no standard test available today. The Disposables Association has accepted a test requiring a four inch head of water to be withstood for four minutes. A variety of other tests have been described (including one by me) but none have been recognized as a standard. The Health Industries Association is presently endeavoring to prepare such a standard for waterproofness for surgical drapes and wrappers for the Food and Drug Administration.

Until the standard is published, nurses and surgeons should demand from sales persons demonstrations of waterproofness. Nonstandard tests are better than none.

A word should also be said about the incorporation of a plastic material between layers of either nonwoven or textiles to insure waterproofness. I had thought that this might be hot and therefore dangerous. Others have felt that I was wrong, stating that if the total material was light in weight, circulation of air would take place beneath the drape or gown. This may well be true from a practical standpoint.

One other observation is worth comment. If the gown's sleeves are waterproof, any stockinette cuff *must* be kept under the gloves wrist. If it is exposed, it will have a contaminating potential.

William C. Beck, M. D., F. A. C. S.
Contributing Editor
Sayre

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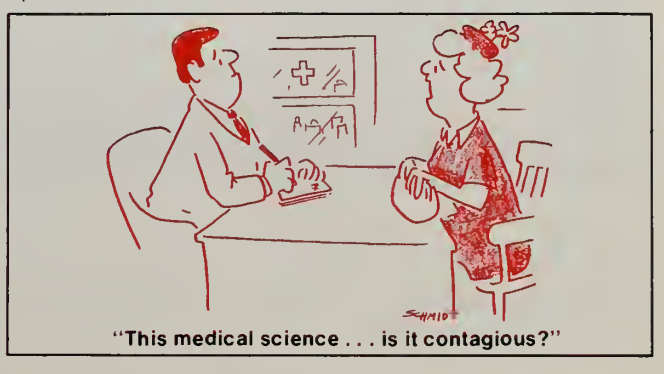


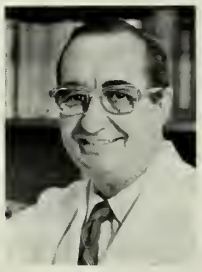
"This medical science . . . is it contagious?"

MDs in the news

Jeffrey I. Damsker, M. D., has been appointed senior instructor in the Department of Radiation Therapy and Nuclear Medicine, Hahnemann Medical College and Hospital. Dr. Damsker graduated from Hahnemann and holds a Junior Faculty Award from the American Cancer Society.

Philip J. Tannenbaum, M. D., has been named vice president and medical director - U. S. for Smith, Kline & French Laboratories. Dr. Tannenbaum is a diplomate of the American Board of Internal Medicine, an instructor of medicine at the University of Pennsylvania School of Medicine, and a member of the American Federation for Clinical Research.

DR. TANNENBAUM



DR. MURTAGH

Frederick Murtagh, M. D., has joined the University of Pennsylvania School of Medicine faculty as professor of neurosurgery and codirector of the department of surgery's neurosurgery division. He is also chief of the neurosurgery division of the university's hospital. Dr. Murtagh is a fellow of the American College of Surgeons and past president of the Philadelphia Neurological Society. He is a member of the American Association of Neurological Surgeons and the European Pediatric Neurosurgical Society.

Mario Ritter, M. D., is the new medical director of the Johnstown Regional Red Cross Blood Center. He replaced **William L. Hughes, M. D.,** on January 1. Dr. Ritter has been secretary and president of hematology of the Sao Paulo State Medical Association and a fellow of the Rockefeller Foundation.

Daniel E. Hill, M. D., has been board certified in pathology and **Prayad Chayapruks, M. D.,** in nuclear medicine recently. Dr. Chayapruks is also certified in internal medicine.

DR. HILL

DR. CHAYAPRUKS

Louis P. DeGennaro, M. D., Elmhurst, has been certified recently as a diplomate of otolaryngology. Dr. DeGennaro is affiliated with a number of professional organizations including the Pennsylvania Academy of Ophthalmology and Otolaryngology and the American Council of Otolaryngology.

William A. McClellan, M. D., has been appointed medical director of Gulf Oil Corporation. He was formerly associate medical director. Before joining Gulf, Dr. McClellan was director of clinics at Milwaukee County Hospital and associate professor of preventive medicine at Marquette University. He is president elect for the Texas Industrial Medical Association and is a fellow of the American College of Preventive Medicine, the American College of Chest Physicians, and the American Industrial Medical Association.

Jonathan E. Rhoads, M. D., professor of surgery at the University of Pennsylvania School of Medicine and chairman of the National Cancer Advisory Board, has been elected recently to the board of directors of the Fox Chase Cancer Center. Dr. Rhoads is editor of the magazine, *Cancer*, a past president of the American Cancer Society, and president of the corporation of Haverford College.

During its 110th anniversary dinner, the Allegheny Medical Society presented a number of awards to various members. **James T. McLaughlin, M. D.,** Pittsburgh psychiatrist, received the Frederick M. Jacob Physician Merit Award for long-term and outstanding service to the county society.

A new award, the Nathaniel Bedford Medallion for long-term dedication to direct patient care was given to **Richard C. Snyder, M. D.** The award bears the name of Pittsburgh's first physician, a former surgeon in the British army during the American Revolution.

Also announced was the establishment of the Ralph C. Wilde Award, in memory of the late president of the county and state medical societies. The award is to be presented, when merited, to a physician "exemplifying those qualities as physician, teacher, leader and human being" which characterized Dr. Wilde.

Edward J. Stemmler, M. D., has been appointed the new dean of the School of Medicine of the University of Pennsylvania. He had been acting dean since 1974. Dr. Stemmler is a fellow of the American College of Physicians and a member of the Association of American Medical Colleges.

DR. STEMMLER

DR. PIETRUSKO

Robert G. Pietrusko, M. D., has been appointed to the editorial board of *Drug Intelligence and Clinical Pharmacy*. Dr. Pietrusko is director of the Northcentral Pennsylvania Drug Information Service and assistant director of Pharmacy for Education and Information at Williamsport Hospital.

Two physicians associated with Annie M. Warner Hospital, Gettysburg, recently spent two weeks on a volunteer medical mission in Honduras, Central America. **William R. Beckman, M. D.,** and **Elizabeth T. Wood, M. D.,** accompanied by registered nurses Judith G. C. Kalbaugh, Mary H. Schroeder, and Irene Paige, ministered to the medical needs of persons in the primitive areas of Honduras in an attempt to improve conditions created by hurricane Fifi.

Baruch S. Blumberg, M. D., associate director for clinical research at the Institute for Cancer Research in Philadelphia and professor of medicine at the University of Pennsylvania, recently received the 1975 Award for Distinguished Achievement from *Modern Medicine*. The award was given for his work with Australian antigen and its causal relationship to viral hepatitis.

Nicholas W. DiCuccio, M. D., Lock Haven, has been certified recently by the American Board of Surgery. He is registered with the American Board of Medical Specialists and listed in Who's Who in America.

Vernon Morgan, M. D., was recently named a fellow of the American College of Surgeons. Dr. Morgan is a member of the American College of Obstetricians and Gynecologists and secretary treasurer of the Central Pennsylvania Gynecological Society.

Joseph M. Clark, M. D., Lebanon, recently received certification as a specialist in nuclear medicine from the American Board of Nuclear Medicine.

Neil Wald, M. D., has been named chairman of the Governor's Advisory Committee on Atomic Energy Development and Radiation Control of the Commonwealth of Pennsylvania. He has been a member of that committee since 1968. Dr. Wald is professor and chairman of the department of radiation health at the University of Pittsburgh Graduate School of Public Health and professor of radiology in Pitt's School of Medicine.

Millard N. Croll, M. D., professor of radiation therapy and nuclear medicine, Hahnemann Medical College and Hospital, is the chairman of the local arrangements committee and a member of the program committee for the annual meeting of the Society of Nuclear Medicine, which will be held in Philadelphia next June.

At the 91st annual dinner of the Luzerne County Medical Society on January 18, 1975, **George J. Brilmyer, M. D., Lawrence F. Corrigan, M. D., George B. Dornblaser, M. D., Edward J. Kieler, M. D., Julian S. Long, M. D.,** and **John W. Woehrle, M. D.,** received plaques for having practiced medicine for fifty years.

Sheo N. P. Srivastava, M. D., Johnstown, has been elected an affiliate in the American College of Cardiology. He is also an associate fellow of the American College of Chest Physicians and the American College of Angiology.

Five senior retired medical staff members of Franklin Hospital, Franklin, were honored recently by members of their community. **D. C. Blanchard, M. D., George S. Smith, M. D., Norman K. Beals, M. D., C. A. Nordstrom, M. D.,** and **G. C. McCandless, M. D.,** together represent approximately 200 years of community medical service.

The Union County Medical Society recently honored **Amos Persing, M. D.,** Watsontown. Dr. Persing, a practicing physician since 1928, was honored for "outstanding courage and devotion to the profession."

VISITING State Society Headquarters for a day of secretarial orientation recently were newly elected county society secretaries. In the photo on the left are Frederick P. Spin, M.D., Bradford County Medical Society, and Robert L. Lamb, PMS director of communications. In the photo above are, left to right, Edward A. Lottick, M.D., Luzerne County Medical Society, and Betty L. Cottle, M.D., Blair County Medical Society, visiting with Dale E. Yates and Donald N. McCoy, State Society staff members.

MDs in the news

Nine Philadelphia medical centers and twenty-five young physicians have been granted American Cancer Society (ACS) support for specialized training in cancer diagnosis and treatment, James G. Bassett, M. D., ACS Philadelphia Division president, has announced.

Medical institutions received a total of $96,000 to enable their faculties to select and train fellows in cancer work next year. Funded were: Albert Einstein Medical Center; Children's Hospital of Philadelphia; Hahnemann Medical College and Hospital; Jefferson Medical College; Mercy Catholic Medical Center; Pennsylvania Hospital; Temple University Health Sciences Center; and the University of Pennsylvania Graduate Hospital and School of Medicine.

Fellows selected as recipients of $137,940 in grants that were awarded to area hospitals to be in effect this year were named as follows:

Physicians awarded clinical fellowships at $4,800 each: Dean R. Wasserman, M. D., at Albert Einstein Medical Center; Thomas R. Kinney, M. D., and Beverly Jane Lange, M. D., at Children's Hospital of Philadelphia; Jack Feldman, M. D., at Episcopal Hospital; Joel M. Nass, D. O., and David B. Plone, D. O., at Hahnemann Medical College; Robert Lustig, M. D., William J. Sieper, D. O., and Stanton F. Carroll, M. D., at Jefferson Medical College; F. X. McBreaty, Jr., M. D., and Howard A. Faren, M. D., at Pennsylvania Hospital; John M. Shaw, M. D., and Allan R. Serviss, M. D., at Temple University; David M. Blom, D. O., at Graduate Hospital; DuPont Guerry IV, M. D., Alan Ve Richman, M. D., Corinne Devereux, M. D., Arthur S. Brown, M. D., and W. Robert Rout, M. D., at the University of Pennsylvania School of Medicine.

Five more physicians who were awarded junior faculty clinical fellowships which range from $6,000-$10,000 according to seniority are: Jeffrey I. Damsker, M. D., and John R. Glassburn, M. D., at Hahnemann Medical College; Paul A. Demare, M. D., and Ralph R. Dobelbower, Jr., M. D., at Jefferson Medical College; and William G. Negendank, M. D., at the University of Pennsylvania School of Medicine.

Your man in Lemoyne

State Society trustees represent members

With this issue of PENNSYLVANIA MEDICINE we initiate a series of profiles of the twelve trustees and councilors of the State Society—the men who make decisions for your organization between sessions of the House of Delegates. Most of you know at least one of them—the one from your district, but the trustees represent all of the members, and are interested in what you are thinking. So that you may know them all, as physicians and human beings, this special feature of M.D.s in the news is presented.

Donna Wenger
Communications Division

Dr. Cooper—First District

Twenty-five years ago, a young physician left Michigan, where he had been born, raised, and schooled, and moved to Pennsylvania. In Philadelphia, where he settled, he went on to distinguish himself and his profession primarily through association with the Medical College of Pennsylvania and the University of Pennsylvania. Today, when Donald R. Cooper, M. D., refers to himself as a transplant from Michigan, he is quick to note that Philadelphia has been kind to him.

Donald R. Cooper attended the University of Michigan, completing there both undergraduate training in 1939 and medical school in 1942. He also served his internship (1942-43) and residency (1946-50) at the University of Michigan and its hospital. He spent the intervening years of 1943-1946 in the U. S. Army with the 298th General Hospital.

The years since 1950, when Dr. Cooper was cer-

Dr. Gehris—Second District

When asked about his philosophy of medical practice, Leroy A. Gehris, M. D., is likely to reply, "No matter how complicated the practice of medicine becomes, or how much interference there is from government or outside sources, as long as we live by the Golden Rule—do unto others as you would have them do unto you—we are on a firm foundation. Living by this guideline touches our relationships not only with our patients but also with our fellow physicians. After living in medicine for forty years, I can say my patients are my friends, and to me medicine has become a way of life."

Dr. Gehris graduated from Jefferson Medical College of Philadelphia, in 1935, having completed in 1931 his undergraduate training at Albright College. Following an internship and residency, 1935-1939, at Germantown Hospital in Philadel-

Dr. Cooper—First District

tified by the American Board of Surgery and began his surgical career, have been filled with teaching and hospital appointments. Associated with the Medical College of Pennsylvania in various teaching capacities since 1950, Dr. Cooper is currently professor and chairman of the department of surgery, a position he has held since 1959. He also taught in the Graduate School of Medicine of the University of Pennsylvania, from 1950 until 1965, holding last the position of associate professor of surgery.

In addition to his academic career, Dr. Cooper has served numerous hospital appointments. At

Philadelphia General Hospital, Dr. Cooper was chief surgeon from 1956 until 1959 and consultant surgeon from 1959 to 1966. He has been consultant surgeon for the Philadelphia Naval Hospital since 1955, and for the Philadelphia Veterans Administration Hospital since 1957. Dr. Cooper was a member of the Board of Governors of the American College of Surgeons from 1965 to 1974. Active in Philadelphia County Medical Society affairs, he was elected trustee and councilor of the First District of the State Society in 1972.

While Dr. Cooper has published extensively in journals and books, he has not confined his thinking to the frequent concern in his thirty-four publications, gastroenterology. He recently shared some personal concerns on the general advancement of medicine.

"I have two main thoughts. One is the awful feeling that I have a noose around my neck, and that every week somebody in government gives it a tug, pulling the noose a little tighter. We have to do what we can to preserve the free enterprise

Dr. Gehris—Second District

phia, Dr. Gehris began a general practice in Reading, Pa., and served as an associate in general surgery at St. Joseph's Hospital. After three years of practice, Dr. Gehris served 40 months in the U. S. Army, primarily at the Barnes General Hospital, Vancouver, Washington, and in the European Theatre of Operations with the 114th Evacuation Hospital. A tour of duty at Bushnell General Hospital, Brigham City, Utah, doing research on the then untried drug, penicillin, was among one of his more exciting experiences.

In 1946, on his return to his native Reading, Dr. Gehris became an associate on the orthopedic and fracture service staff at St. Joseph's Hospital. He also continued the general practice of medicine in which he was engaged prior to serving his country. He served for twenty years as a member of the executive committee of the hospital and, in 1956, as president. Currently, Dr. Gehris is chairman of the hospital's utilization committee.

This long dedication to surgery and family practice has been complemented by Dr. Gehris' active involvement in organized medicine. As a young physician, he joined the Berks County Medical Society in 1939, and has remained active since then. At the county medical society level, he has participated in most of the important committees, including membership on and chairmanship of the Board of Censors with similar positions on the Grievance Committee. Not only has Dr. Gehris served on county committees, but he also held membership on the Executive Board for 19 years, serving as chairman of the board in 1968 (a position in which the title, "past president," is a requirement). He was president of the Berks CMS in 1958.

In addition to his county activities, Dr. Gehris is also active in the Pennsylvania Medical Society. Beginning in 1954, he served his first year as an elected delegate to the House of Delegates of the State Society. Fifteen consecutive years as a

Dr. Cooper—First District

system. At the same time, we have to recognize the problems that exist. The best way to obviate government interference is for the medical societies to define these problems and propose workable solutions.

"Second, we have to do what we can to correct that divergence of opinion that springs up between practicing physicians and those in medical education. People in medical education have a vital interest in organized medicine; they should lend it their support. On the other hand, people in organized medicine should not assume that educators are against everything they believe in. Organized medicine should realize that medical educators, like themselves, are trying to make medicine better, not worse. These two groups should communicate more, and learn to value each other more."

in action with fellow trustees

Dr. Gehris—Second District

in center of Board activity

member of the House of Delegates followed. Further service at the state level included serving as a member of the Council on Public Service for six years, ten years as a member of the Public Relations Commission, and thirteen as a member of the Commission on Emergency Medical Disaster, five of which he served as chairman. He was the fourth vice president for three years and in 1969 was elected to serve as trustee and councilor of the Second District.

Dr. Gehris is a member of the American Medical Association and the American Academy of Family Physicians. He is the chief of the medical division of the Berks County Civil Defense Council, and has held this position for twenty-five years.

He holds membership in the Kiwanis Club of Reading and is a member of the Holy Spirit Lutheran Church. In 1967, Dr. Gehris received the Brotherhood Award from the Church of Jesus Christ of Latter Day Saints for outstanding service to unfortunate members of the community. This award is a fitting recognition for a physician who would choose to practice his profession by the Golden Rule.

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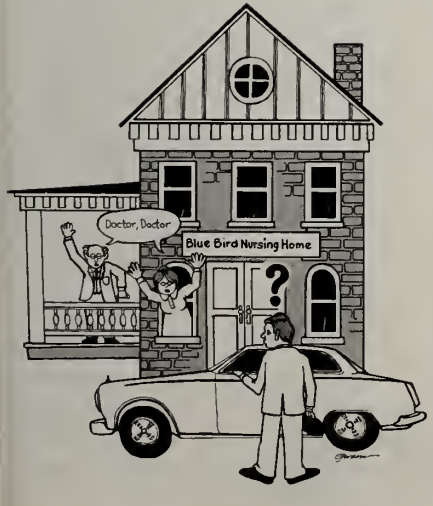
What you should know about medicare

I. R. PERKIN
Camp Hill

This is the third in a series of articles designed to acquaint Pennsylvania doctors with pertinent aspects of the medicare program. The first two articles dealt with Pennsylvania Blue Shield's role in handling doctors' and patients' claims and provided pointers on reducing needless paperwork in the filing of medicare claims.

Since medicare does not pay for *all* medical costs, doctors should also know about limitations on payment for their services. Knowledge of what is *not* covered can avoid doctor-patient relationship problems when a medicare payment is reduced or not allowed by Pennsylvania Blue Shield with a statement such as "Medicare Does Not Pay For This Many Services For Your Condition." Accordingly, this article deals with the subject of services which are eligible for payment under the current medicare law—and those which are not.

The medicare law, passed in 1965, provides the basis for payment to hospitals (Part A) and doctors (Part B). Of continued concern in the administration of the overall program is the steady rise in costs. In 1967, its first year, Part A costs amounted to over $2.5 billion; Part B, almost $1.4 billion. Eight years later, the annual cost for Part A is estimated to be in excess of $9 billion and Part B has increased to over $3.7 billion. Total costs since inception of the medicare program are now estimated to have exceeded *sixty-two billion dollars!*



With this much money involved, is it any wonder that eligibility of medicare services and attendant expenditures are being scrutinized closely? Or that carriers (fiscal intermediaries), such as Pennsylvania Blue Shield, are asked by the Social Security Administration's Bureau of Health Insurance to assure that services provided are indeed "reasonable and necessary?"

To control costs and assure that the dollars spent are directed toward quality medical services, certain specific requirements have been placed upon carriers. These requirements form an integral part of the claim processing and payment system used by Pennsylvania Blue Shield in the handling of medicare claims. Essentially the mechanism employed consists of a series of screens built into a computer-based system to permit interception of certain claims—prior to payment—in which charges and/or services do not appear consonant with the reported diagnosis.

These screens are of three types: (1) those designed to assure that payment is made only for *covered services;* (2) those designed to insure that payments are made on a "reasonable charge" basis, i.e., the lowest of a doctor's billed charge, his customary charge on record, or the prevailing charge in the same area for the same service; and (3) those designed to assist in determining that payment is made only for eligible services which are *medically necessary.*

Thus, covered medical services reimbursed by medicare are services which pass screenings by Pennsylvania Blue Shield in consonance with the general pattern. When a service does not pass screening and is rejected or reduced, a brief explanatory message is given on the *Explanation of Medicare Benefits* form provided by Pennsylvania Blue Shield. This form is furnished to both doctor and patient when assignment is accepted. When assignment is not accepted, only the patient receives a copy.

Services not covered

The following list of items, though not complete, is representative of services which are excluded from coverage:

- Routine physical examinations and related tests
- Routine foot care
- Eye or hearing examinations for prescribing or fitting eyeglasses or hearing aids
- Immunizations (unless required because of an injury or immediate risk of infection)
- Cosmetic surgery (unless needed because of accidental injury or to improve the functioning of a malformed part of the body)
- Prescription drugs and self-administered drugs
- Dental services
- Items and services covered under a Workmen's Compensation Law
- Items or services for which there is no legal obligation to pay
- Charges by immediate relatives or members of household
- Items or services furnished by government instrumentalities

A specific explanatory remark such as "Medicare Does Not Pay For Prescription Drugs" or "Medicare Does Not Pay For Measuring Eye Refraction" appears on the *Explanation of Medicare Benefits* form when Part B payment for such a service is not allowed.

Covered services

Generally, the following are eligible as covered services under Part B:

- Physician's services, including surgery, consultations, home and office visits, institutional calls, and services and supplies provided incident to a physician's professional service
- Outpatient hospital services provided incident to a physician's services
- Outpatient diagnostic services provided by a hospital
- Outpatient physical therapy
- Diagnostic services including x-rays, pathology examination, laboratory service and diagnostic medical examinations
- X-ray, radium, and radioactive isotope therapy
- Surgical dressings, and splints, braces and other devices used for reduction of fractures and dislocations
- Rental or purchase of durable medical equipment for use in the patient's home
- Ambulance services
- Prosthetic devices which replace all or part of an internal body organ
- Leg, arm, back and neck braces and artificial legs, arms and eyes

Limitations to covered services

It is important to recognize that while these covered services are eligible for payment, they are nevertheless subject to certain restrictions. These stem from the specific

contractual charge imposed by the Social Security Administration upon its medicare carriers, i.e., that the carrier shall, **"institute utilization safeguards which include methods of assuring that payments made for Part B services are for covered services which are medically necessary."**

Pennsylvania Blue Shield is discharging this mandate through the use of thirty-seven utilization review screens. These intercept claims for specific medical review prior to payment when they exceed certain cost, frequency and level of service criteria. The screens form the basis for medical necessity reviews of otherwise eligible or covered medicare services. In accomplishing reviews Pennsylvania Blue Shield is guided by the following definition:

> Medical necessity means a need for a particular item or service which is required for the diagnosis or treatment of a disease, injury or defect. This item or service should correlate with the diagnosis or treatment, or with symptoms requiring a differential diagnosis. The need for the item or service should be documented and/or be in conformity with guidelines established by appropriate peer groups. Exceptions to this general definition may require peer review.

In practice, screens intercept claims falling outside of physician-approved parameters for such services as lab charges, medical charges, multiple surgical charges, in-hospital visits, office visits, nursing home visits, skilled nursing facility visits, home visits, injections, etc. When the services exceed such parameters, the claim is examined for reported circumstances which might warrant special consideration.

Examination is first accomplished by specially trained personnel working with medically approved guidelines. When guidelines are unavailable or not feasible, the claim is referred to doctors serving as medical directors or medical advisors for specific medical necessity determinations. In this case, additional information such as operative notes, progress notes, etc., is usually requested. As part of PBS' Medical Advisory System, over 100 doctors (mostly specialists) screen claims and provide guidance or advice. *(Note: The review mechanism followed to accomplish medical necessity reviews was explained in the article which appeared in the January 1974 issue of PENNSYLVANIA MEDICINE entitled "Pennsylvania Blue Shield medicare procedure explained, review mechanism outlined." PBS will be happy to provide reprints upon request.)*

When reductions are made or services not allowed on the basis of medical necessity, the message appearing on the *Explanation of Medicare Benefits* form states either "Medicare Does Not Pay For This Procedure For Your Condition" or "Medicare Does Not Pay For This Many Services For Your Condition."

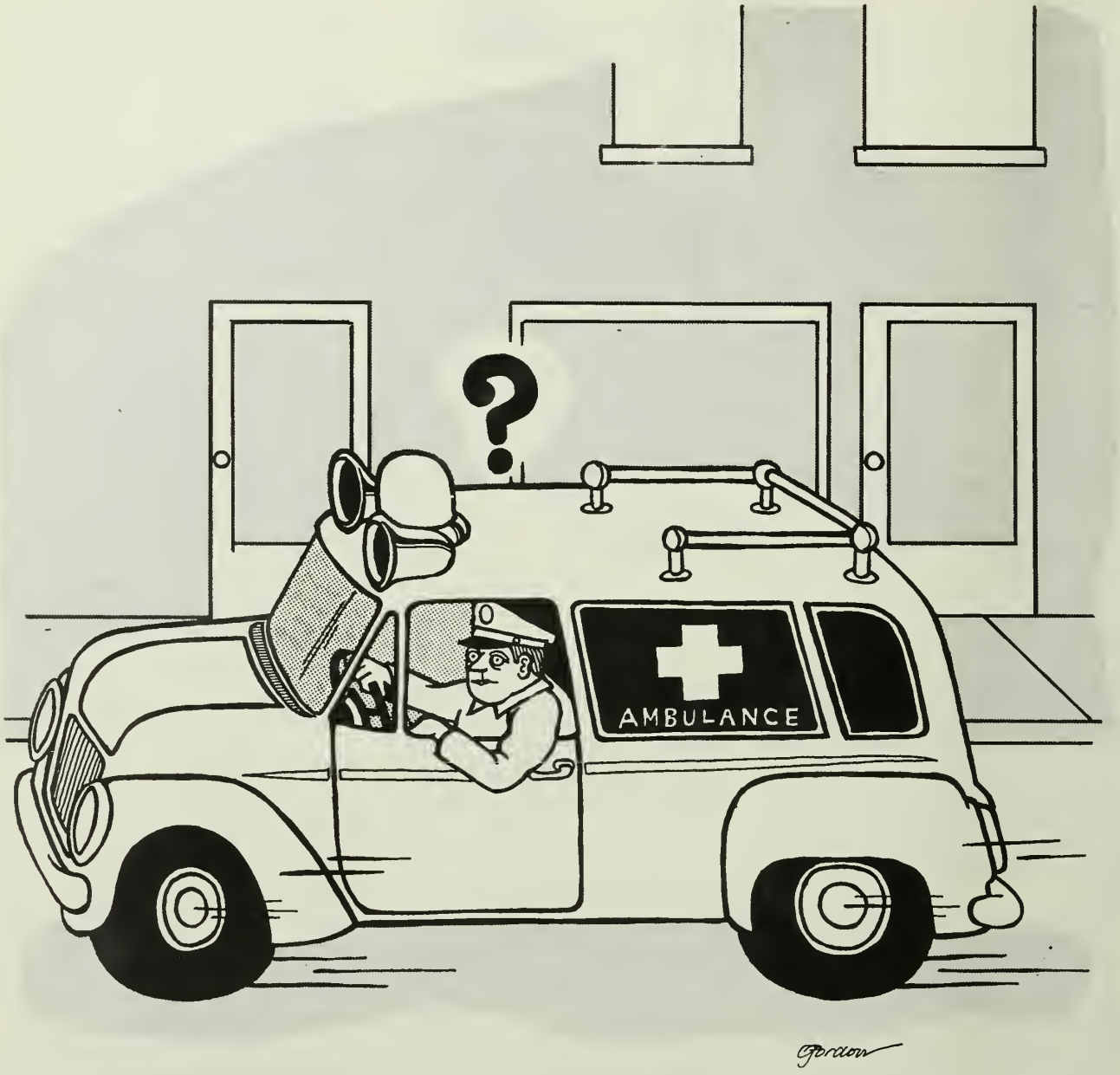
Mr. Perkin is director of medicare operations for Pennsylvania Blue Shield. Articles written by him appeared in PENNSYLVANIA MEDICINE in the January and June 1974 issues. His subject was Blue Shield review of medicare claims.

Payment for eligible services

Following screening as described above, claim payment is made directly to the doctor when he accepts assignment and submits his charges to Pennsylvania Blue Shield on a "Request for Medicare Payment" form (Form 1490). When a doctor does not accept assignment and bills the patient directly, the patient submits the same form, with the bill attached, and payment is made to the patient.

In either case, the *Explanation of Medicare Benefits* form, which accompanies the payment check, lists the amount billed, the amount approved, and provides a brief explanation of the reason for the difference, if any. An accounting is also provided to show the amount applied to the patient's annual deductible (if pertinent) and the amount subject to reimbursement at 80 percent as provided for in the medicare law.

Since billing problems can cause patient misunderstandings, doctors should be aware of the possible adjustments to submitted charges for services and the actual payment that is made (which may be less than the submitted charge). These



adjustments can occur as the claim passes through Pennsylvania Blue Shield's claims processing system which provides for a three-fold examination to insure that (1) the service is covered and thus eligible for medicare reimbursement, (2) the charge is "reasonable" (lowest of actual, customary or prevailing charge), and (3) the service is medically necessary in consonance with the diagnosis given.

Appeals

The medicare program also provides recourse for doctors to question reductions or denials for services. A request for review will result in a special re-examination of the claim. Frequently, additional information accompanying the request can justify readily the medical necessity for an added charge or service which was not apparent during initial processing.

If dissatisfied after review, a doctor is entitled to a medicare fair hearing if the amount in controversy is $100 or more (either a single claim or total of several claims). During the hearing, conducted by an impartial hearing officer, the doctor or his representative may offer evidence in person or by mail. He may present his own witnesses or examine the carrier's. Medicare law does not provide for any further appeal or for judicial review by state or federal courts.

In summary, doctors should recognize that eligible medicare services are subject to certain payment constraints. Payment ground rules employed by Pennsylvania Blue Shield, in accordance with its contractual obligations to the Social Security Administration, may affect reimbursement for medical charges. Should a doctor feel that he has been treated unfairly, or in error, two separate and distinct avenues of appeal are available for review of medicare payments. □

Acupuncture—an attitude and perspective

NATHAN SUSSMAN, M. D.
Harrisburg

THE TIME is long past when the medical profession as a whole must take a realistic position on the status of acupuncture. To date, because of the publicity initiated with columnist James Reston's experience in China, the demand for this modality has become a cacophonous clamor created by those in search for a cure or relief from pain. In its wake several interesting phenomena took place, the first of which has been the ever growing number of people migrating to a variety of acupuncture centers where treatment with this modality is provided for an extensive spectrum of medical ills and pains. Many of these centers are staffed by acupuncture technicians fresh from the Orient who present a communication problem because of a language barrier. Consequently the rapport that they might establish with the patient seeking help is questionable.

As far as the medical profession is concerned this has created a cleavage in thinking and attitude. There are those who deny the existance of any therapeutic potential from this procedure and glibly rationalize any merit on hypnotism or a placebo effect. On the other hand, there are those who champion its efficacy and the degree of enthusiasm will vary with their active and passive experience, particularly by the good results that have been achieved without taking into account the balancing effect when negative results have materialized. In the middle we have those who take no definitive stand and make no effort to study the subject either from its academic interest, because of its ancient beginnings, or as a potential in assisting them in caring for their patients.

In retrospect, the use of acupuncture as such has been known by physicians in western medicine for well over a century. William Osler in his text prior to the turn of the century supported the use of acupuncture for backache. In France, following the return of Jesuit missionaries from China came the technique they observed in the Orient. Because a goodly number of people received fair to excellent results, the popularity of this procedure spread to other countries.

Those physicians who pursue their studies in electrophysiology, when using such diagnostic procedures as chronaximetry, strength duration curves, or electromyography, are certainly well qualified in the selective placement of needles or surface electrodes. All that is needed is orientation in the utilization of this modality for its therapeutic impact and not for diagnostic purposes alone. Furthermore, a rapidly growing body of knowledge is already available in support of this procedure—especially with electronic stimulators. It is imperative to look upon the concept of acupuncture as a modality and not a speciality.

All medical schools and teaching centers could supplement the courses in anatomy and physiology with some orientation in this therapeutic approach. In addition they should provide an opportunity for those physicians interested in learning the technique to take courses at a nominal cost, thereby erasing the excessively expensive courses that have sprung up in this country. Thus as a modality in an established therapeutic armamentarium, it could be made available for those patients for whom conventional therapy has failed to achieve its objective. There should be no need for anyone to travel distances in order to visit those who practice acupuncture exclusively or to special centers where acupuncture may be obtained. Realistically, it should be provided by local physicians as a part of a holistic program when indications exist, just as a patient may receive diathermy or ultrasound adjunctively to a basic therapeutic regimen.

Although the precise mechanism of the function of acupuncture remains to be identified and caution is advocated, its proven efficacy in many areas justifies its clinical utilization by physicians. □

Dr. Sussman has developed an interest in acupuncture over a number of years and serves in an advisory capacity in that area for the PMS Council on Education and Science. He is medical director of the Dauphin County Home and Hospital and maintains a private practice in internal medicine in Harrisburg.

Physician manpower report

Shows need for more primary care physicians

KENNETH B. JONES
Pennsylvania Medical Society

The Commission on Education and Manpower met December 11 to work on the reports printed in this issue.

Several ad hoc and standing committees of the Pennsylvania Medical Society have gathered some basic information on physician numbers and distribution in Pennsylvania. The Commission on Education and Manpower, the key committee involved, has some reluctance about interpreting these figures publicly. This is based on the inadequacy of the most commonly used measurement, the physician to population ratio, and of answers to the question of "what is an adequate ratio."

The physician to population ratio is essentially an attempt to measure supply and demand by counting buyers and sellers. Ignored are differences in disease incidences, in physician productivity, and in social and economic factors. Ratios simply do not measure services available versus demand for those services. Ratios become increasingly suspect when applied to smaller and smaller geographic units because of patient movement across unit lines and because of necessary concentrations of specialists near appropriate facilities. Finally, virtually universal disagreement exists as to what constitutes a favorable ratio. Yet because of the lack of better measurements, the physician to population ratio remains the generally accepted means of determining the demand for physicians.

This paper intends to speak in terms of numbers and to interpret what those numbers mean. There are several reasons why it is necessary to do so despite misgivings. It is necessary now to be more specific in physician manpower projections than it has been. For example, it was possible to agree in 1953 that medical school enrollment should be increased, while differing considerably on how much of an increase was needed. Since 1953 medical school enrollments have increased substantially and the question of how much of an increase which could be ignored in 1953 must be answered now. It has been recommended that family practice residencies in Pennsylvania be increased. Family practice residency programs in Pennsylvania have increased from one in 1969 to 18 today. Again the question of "how much" has to be answered.

State government, too, has seen the need for some basic studies on health manpower, to a large degree because of the Legislature's concern with the funding of undergraduate medical education. Our conclusions on some issues differ from the conclusions resulting from that research.

Finally, there is our suspicion that the general supply of omniscience is limited and that our particular portion is small. Physicians and county medical societies know better whether there is a need for additional physicians than most planners suspect. The accusations made here, it is hoped, will be corrected by those with a closer view.

Using qualifying statements creates a disadvantage as opposed to speaking with unfounded certainty. But qualifications to and questioning of the basic premises are necessary to an understanding of the issues. These have been stated in this introduction. The remainder will be presented with a degree of uncertainty. The qualifications, however, are essential to an understanding of what follows.

Are there enough physicians in Pennsylvania?

In part because of the scarcity of specific considerations of Pennsylvania and in part because the situation in Pennsylvania is reflective of the situation in the nation as a whole, an examination of the physician shortage in the United States should prove helpful.

In the late 1950s, concern over a national physician shortage increased. By the middle of the 1960s, implementation of some of the solutions proposed for the physician shortage had begun. The most obvious actions taken included federal and stage efforts to subsidize medical education in the form of per capita grants and efforts of medical schools themselves to expand classes and/or change programs and shorten curriculum. These efforts were successful. In 1963 there were some 87 medical schools with 32,000 students. In the fall of 1974 there were 114 schools and 52,500 students. Nationally, the number of physicians increased in this period from 289,000 to 380,000, with new physicians being licensed at a rate of 17,000 per year. This increase of 32 percent in physician numbers outdistanced the 11 percent increase in population. Medical school expansion has not yet run its course. Further increases in physician numbers can be expected.

Two factors in addition to medical school expansion played a role in meeting the need for medical services. One is the influx of foreign medical graduates, due in part to the passage of the 1965 Immigration and Naturalization Act. In 1972 about 46 percent of the licentiates representing additions to the medical profession were graduates of foreign medical schools. Five years before, this percentage was 22.1. Approximately 19.5 percent of the physicians in the United States by 1973 were foreign medical graduates. Another factor is an increasing use by physicians of allied medical personnel. The trend recently has been for physicians to use greater numbers of assistants, thereby increasing physician productivity. The most highly publicized effort in this area has been the development of the physician's assistant concept. In 1963 there were no physicians' assistants programs in the United States. There are some 80 recognized schools today.

The concern of national experts now is that the nation has over responded to the physician shortage of the 1950s and 1960s and that an oversupply of physicians will result, perhaps as early as 1975. Clark Kerr, chairman of the Carnegie Commission on Education, was quoted recently as saying that the recommendations of the Carnegie Commission regarding medical school expansion had been reached and that oversupply is the concern now. The Council on Medical Education of the AMA in its reports to the House of Delegates over the last several years has made mention of its estimates that oversupply was likely. At the same time, there is growing concern in the Department of Health, Education, and Welfare over the possibility of physician oversupply. This concern is reflected in the budget request for funding medical education and in proposed legislation suggesting changes in the spending formula for the support of medical education.

Pennsylvania Estimates

If Pennsylvania's physician to population ratio were significantly worse than the nation as a whole, applying these national projections of potential oversupply would yield no conclusive answers. However, Pennsylvania ranks in the top eleven states in physician to population ratio and has a ratio better than the national average. National estimates of potential oversupply are thus especially applicable.

In 1973 Pennsylvania had one physician for every 627 people. Pennsylvania now has a better physician to population ratio than at any time in the last 68 years and probably in its history. The Department of Health, Education, and Welfare has suggested in relationship to its loan forgiveness program that the dividing line between favorable and unfavorable ratios was one physician to every 1,500 people and this figure was used in a Department of Health publication, "Licensed Health Personnel in Pennsylvania: A Geographic Distribution." Another possible dividing point between favorable and unfavorable physician to population ratios can come from Health Maintenance Organizations which "plan" their ratios of physicians to population.

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Ratios vary from one HMO to another but the lowest is one physician to 1,000 people. By these criteria and others, Pennsylvania should have more than an adequate supply of physicians. It is interesting to note that Canada, with a physician to population ratio of one to 630, is now considering the establishment of immigration and regional quotas to correct the problem of anticipated *oversupply*.

Two dissenting views should be mentioned.* The first indicates that one *primary care* physician is needed for every 744 people. While no estimate is made of the total number of physicians needed, the addition of specialist physicians would put the suggested ratio under Pennsylvania's present ratio. The second is a study specifically on Pennsylvania which suggested that in 1973 there was need for an additional 4,565 physicians in direct patient care in Pennsylvania.

Projections

Projections for the next five to ten years depend in part on the answers to questions now being posed concerning the recent upsurge in the number of foreign medical graduates staying in this country. Pennsylvania's circumstances roughly parallel the national situation. Foreign medical graduates numbered 3,557 of Pennsylvania's 18,764 M. D. s in 1972, filling some 27 percent of Pennsylvania's residency positions. Last year more than half of the new licenses granted in Pennsylvania were granted to foreign medical graduates. F. M. G. s made up some 41 percent of the Pennsylvania Medical Society's new membership in 1973.

This rapid increase in the number of foreign medical graduates is being questioned. The Association of American Medical Colleges' Task Force on Foreign Medical Graduates has recommended that foreign medical graduate influx into the United States should be halted or slowed by restricting the number of residency training positions available. Recommendations of a similar nature have been made by other expert bodies, including the National Advisory Commission on Health Manpower.

Because of the complexities of physician migration patterns, it is difficult to make definitive projections but restriction of the inflow of foreign medical graduates would mean for Pennsylvania a decline in the *rate of increase* of physician numbers in Pennsylvania. It would not mean, however, a decline in physician numbers or a worsening of the physician to population ratio. The Bureau of Labor Statistics has estimated that physicians leave practice through death or retirement at a rate of 1.8 percent per year. Applied to Pennsylvania's 1973 M. D. population of 18,764, the replacement need is approximately 350 M. D. s per year. This number would be supplied through the present retention rate of 40 percent of Pennsylvania medical school graduates based on 1,000 graduates each year. In addition, Pennsylvania attracts a little more than 2 percent of the total physicians graduated from U. S. medical schools outside of Pennsylvania (roughly 9,500 physicians). This means approximately 190 additional physicians are added to Pennsylvania numbers each year. Other factors, including a net immigration rate of around 130 per year into Pennsylvania, inclusion of graduates of Canadian schools and the stabilization or decline in population in Pennsylvania make a strong case for the position that with or without foreign medical graduates Pennsylvania physician to population ratios should continue to improve.

Specialty distribution

While total physician numbers are adequate, there is evidence that shortages exist in the numbers of primary care physicians. From 1963 to 1973 the number of general/family practice physicians declined by 19,543 (minus 26.6 percent). However, internal medicine gained 22,626 physicians (plus 57.9 percent) and pediatrics 6,642 (plus 46.8). These three primary care specialties taken together increased by 9,725 or roughly 8 percent while the population as a whole increased 11 percent. The trend toward decreasing numbers of family physicians goes back at least as far as the 1930s when about 75 percent of all physicians were in general practice. Until very recently support for increasing percentages of specialists came from virtually all sectors of society. Third party payment was often greater for the same procedure if performed by a specialist. The public sought out and took pride in going to the specialist. Medical schools encouraged specialization. The federal government itself rewarded specialists in various ways. The driving impetus was the vast increase in the scope and complexity of medical knowledge.

Most indications are that the nation has gone too far in the trend toward specialization. Most authorities (including many warning of an oversupply of physicians) agree that there is a shortage of primary care physicians. This concern over the primary care physician shortage has been reflected in positions taken by the American Medical Association and in legislation before the United States Congress. Both the American Medical Association and the Pennsylvania Medical Society's Physician Placement Services show many more requests for general practitioners than from general practitioners seeking positions. Health Maintenance Organizations, despite the obvious possibility of replacing the family physician with a multi-specialty group, still generally have better ratios than Pennsylvania.

As might be expected, there is little agreement on the extent of the shortage. Suggestions of favorable ratios vary so widely that depending on what ratio is chosen, a case could be made for anything from an enormous shortage to a presently adequate supply. One rejected alternative, however, should be mentioned specifically. There appeared in *Medical Economics* recently a survey of specialty societies which asked the specialties what ratios they themselves felt would be appropriate for their specialty. The table from that article is included along with corresponding Pennsylvania ratios, (Appendix B).

There are several reasons for rejecting that approach and the other approaches based on ratios

*See references: Brehman and Schonfeld.

where it is possible. First, there is the already mentioned problem with the physician population ratios in general and the resulting lack of specific reasons for choosing one ratio over another. The second is a problem of definition. It is necessary to define primary care in terms of specialties. The AMA designation of primary care means the specialty of general practice/family practice, internal medicine and pediatrics. The AMA definition is preferable to other definitions but it does have some serious drawbacks. All internists and all pediatricians are not generalists; in terms of primary care services then the internists and pediatrician total numbers are too high. In addition, only 48 percent of the internists and 61 percent of the pediatricians list with the AMA their primary activity as direct patient care, as compared to general/family practitioners, 94 percent. Looking from the other angle, physicians engaged in obstetrics and gynecology deliver a great deal of primary care as do many general surgeons. Estimates have from time to time been made of the percentage of non-emergency cases seen by the emergency physician; generally these estimates were well over 50 percent. There is also the unanswered question of what is a desirable mix between generalists and specialists. If there are adequate numbers of specialists, particularly in the medical specialties and general surgery, then the total number of primary care physicians needed should be less. The study of HMO specialty ratios indicates little if not that various mixes of specialties can be used to deliver the same quantity of basic care.

Suggested approach

It is virtually impossible to piece together the trends of declining numbers of family physicians, increasing numbers of internists and pediatricians and increasing numbers of physicians into a definitive statement of how many physicians are needed in the primary care specialties. At the same time, it is clear the decline in the number of direct patient care physicians in these three specialties should be halted. Given the uncertainties about ratios and appropriate mixes of physicians, a pragmatic trial and error approach seems to be the feasible course. An increase of 25 percent in these specialties is well within the conservative range of other estimates. The suggestion made here is that the Commonwealth move quickly toward reaching that arbitrary 25 percent increase in primary care physicians while at the same time seeking better answers to physician demand questions.

Table I gives present numbers and ratios and those that would result if there were a 25 percent increase.

TABLE I

	Present Numbers (Ratio)	*25% Increase (Ratio)*	*Present National Ratio*
General Practice/ Family Practice	3120 (1/3815)	3900 (1/3051)	(1/3851)
Internal Medicine	2453 (1/4852)	3066 (1/3882)	(1/4160)
Pediatrics	978 (1/12,170)	1223 (1/9732)	(1/10,400)

TABLE II

	Increase Needed	*M. D. Res. Per Yr.*	*Replace Per Year*	*Total Per Year*	*Present Slots First Yr.*
General Practice/ Family Practice	780	78	125	203	92 (59% F.P.-Filled) (63% G.P.-Filled)
Internal medicine	613	61	40	101	266 (94% Filled)
Pediatrics	245	25	13	38	95 (93% Filled)

Table II is an attempt to estimate, assuming Pennsylvania is a closed system, how many primary care physicians it would need to train each year on the undergraduate and graduate level to replace retiring physicians and increase the total in each specialty by 25 percent. Column 1 gives the number of physicians a 25 percent increase represents; Column 2 is Column 1 figure spread over a ten-year period; Column 3 is an estimate of the numbers of physicians that will need to be replaced because of death or retirement per year over that ten-year period based on the total number of physicians in those specialties 58 or older; Column 4 is the total of Column 2 and 3. Both Table I and Table II assume that the present balance between the number of family physicians, internists and pediatricians should be maintained. Column 4 (total needed per year) also applies to medical school graduates.

Geographic distribution

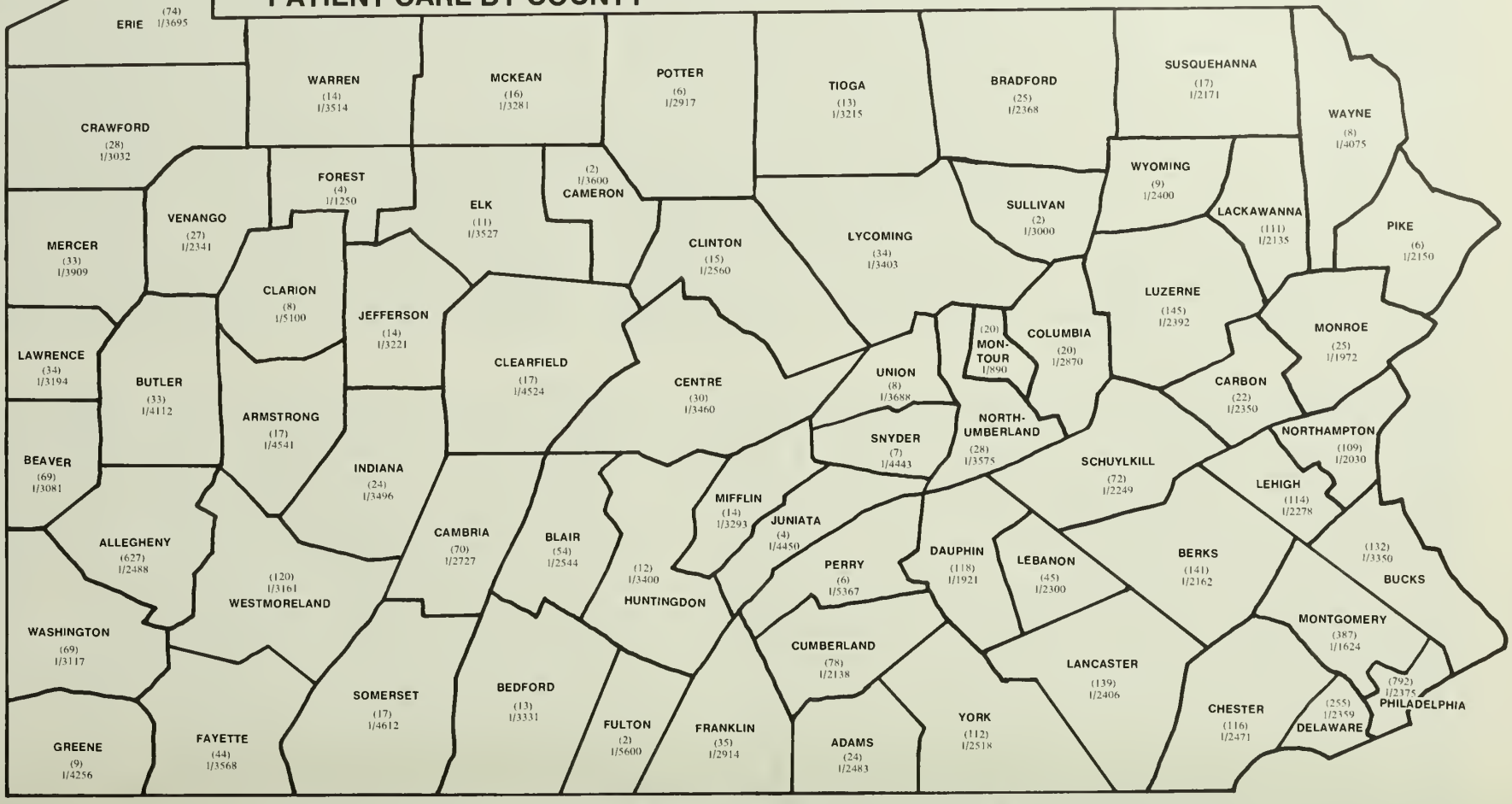
A glance at physician to population ratios in different Pennsylvania counties shows that physicians are not evenly distributed throughout the state; not surprisingly the ratios in metropolitan areas are much better than those in rural areas and the counties west of the Susquehanna River have in general poorer ratios than those east of the Susquehanna River.

The ratios by county are presented on the maps, making it much easier to see relationships between ratios in a given geographic area. Also included is the number of physicians in each county so that it will be easy to aggregate ratios. Obviously the county is not a self-contained medical care unit and it is necessary for even a cursory evaluation to consider surrounding counties.

There is also need to consider various specialties differently. Many specialties are hospital related. The anesthesiologist, for example, must locate in a hospital. Argument has been made that the distribution of these hospital-related specialties should be considered not on the basis of counties but on the basis of hospitals and more exactly the size of the hospital, which in turn should be reflective of referral patterns and the flow of medical services.

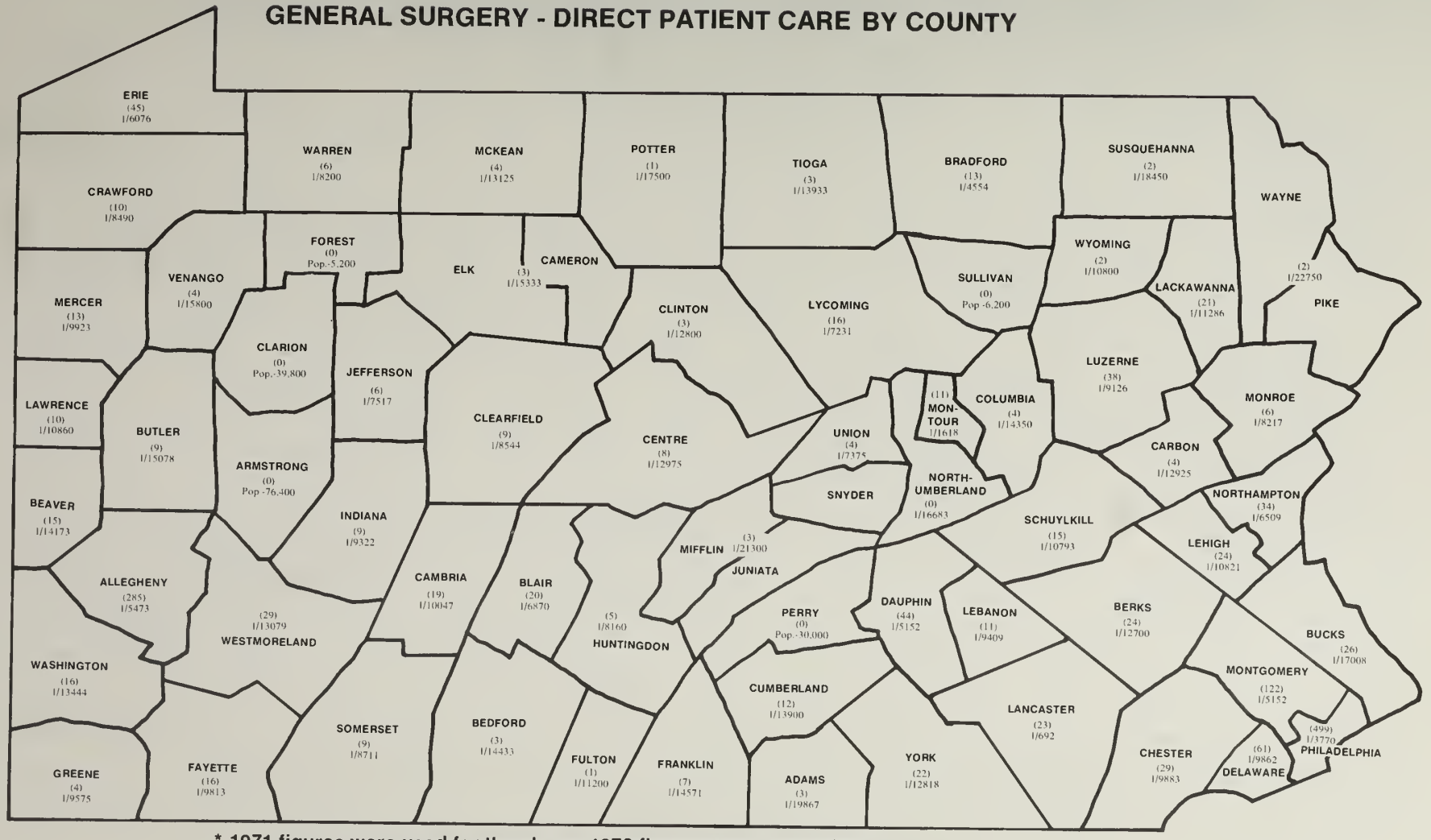
The main concern on the county level should be the

INTERNAL MEDICINE, PEDIATRICS, FAMILY PRACTICE/GENERAL PRACTICE - DIRECT PATIENT CARE BY COUNTY



Numbers in parentheses indicate total number of primary care physicians in direct patient care.

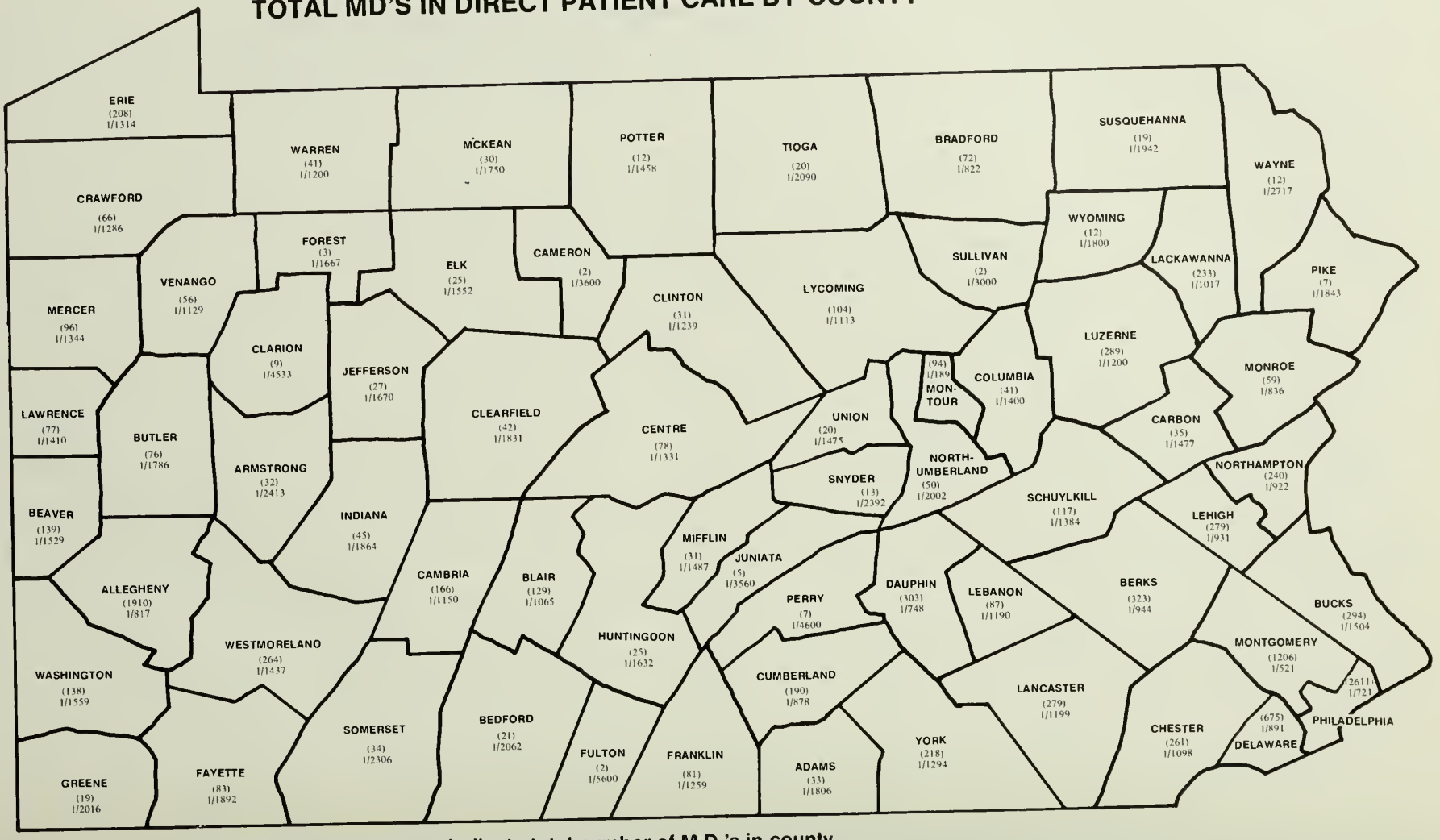
GENERAL SURGERY - DIRECT PATIENT CARE BY COUNTY



* 1971 figures were used for the above; 1973 figures were not available.

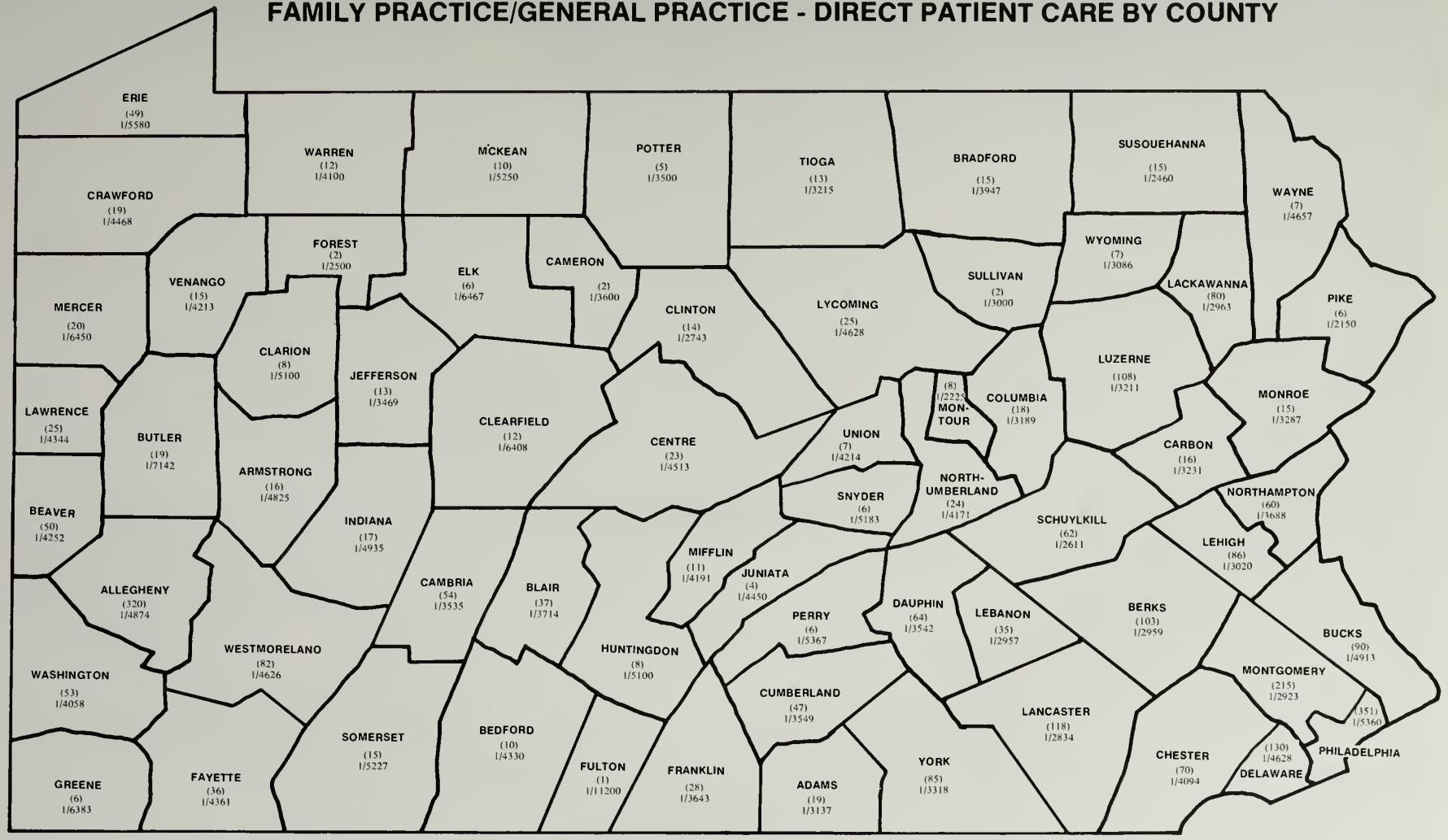
Numbers in parentheses indicate total number of general surgeons in county.

TOTAL MD'S IN DIRECT PATIENT CARE BY COUNTY



Numbers in parentheses indicate total number of M.D.'s in county

FAMILY PRACTICE/GENERAL PRACTICE - DIRECT PATIENT CARE BY COUNTY



Numbers in parentheses indicate total number of physicians in family practice/general practice in county.

distribution of primary care physicians. Because a mix of specialists who provide primary care does vary considerably, ratios have been given for family/general practice and for the three primary care specialties in the aggregate. A map showing distribution of general surgeons has also been included as an example of a specialty in oversupply. That map is particularly interesting if compared to primary care maps, for it shows a considerable oversupply of general surgeons in many areas where there is a shortage of primary care physicians. The problem may not be a problem of a shortage of primary care physicians but rather the problem alluded to earlier of defining primary care in terms of specialties.

Finally, it should be noted that the maps give ratios in terms of direct patient care physicians rather than physicians.

Conclusions

In a sense, this is a paper that says there are no definitive answers. Hopefully no one will read the conclusions below without first reading the introduction which points out the uncertainties.

1. There is a need for better evaluation of the demand for physicians.

2. There is no overall physician shortage; the present numbers of physicians in Pennsylvania are adequate and the number of physicians to population should continue to improve. A better case can be made for an imminent oversupply of physicians than can be made for physician shortage.

3. There is a shortage of primary care physicians and an oversupply in some other specialties. The number of general family physicians is declining and will continue to decline unless efforts are made to halt that decline. More specifically, residency slots in family practice are inadequate to maintain the present number of family/general practitioners and probably medical school student interest is also inadequate. Losses in the number of family physicians should be partially offset by increasing numbers of internists and pediatricians.

4. There is an uneven distribution of physicians across the state. The same quantity of medical care is not available to all Pennsylvania citizens.

Appendix A

Total Nonfederal Physicians for Pennsylvania in Relation to Population and Area from 1906 to 1970*

Year	Pop.[1] (000)	Physicians[2]	People Per Physician[3]	Area (Sq. Mi.) Per Physician[3]
1906	7,110	9,957	715	4.5
1909	7,546	11,056	681	4.1
1912	7,986	11,345	694	4.0
1914	8,276	11,611	696	3.9
1916	8,463	11,502	721	3.9
1918	8,524	11,495	740	3.9
1921	8,900	11,348	776	4.0
1923	9,148	11,241	800	4.0
1925	9,478	11,140	824	4.0
1927	9,745	11,405	821	3.9
1929	9,723	11,795	809	3.8
1931	9,707	12,051	801	3.7
1934	9,795	12,608	772	3.6
1936	9,767	12,889	760	3.5
1938	9,952	13,205	746	3.4
1940	9,900	13,529	732	3.3
1942	9,704	13,503	742	3.3
1949	10,390	14,207	735	3.2
1955	10,939	14,727	733	3.1
1957	10,954	14,507	753	3.1
1960	11,319	15,058	752	3.0
1963	11,408	16,030	712	2.8
1964	11,505	16,278	707	2.8
1965	11,618	16,602	698	2.7
1966	11,657	16,814	693	2.7
1967	11,672	17,163	680	2.7
1968	11,750	17,365	677	2.6
1969	11,772	17,584	669	2.6
1970	11,794	17,876	660	2.5

[1] Population estimates obtained from *1970 Pennsylvania Statistical Abstracts* prepared by the Pennsylvania State Bureau of Statistics, Table 5, page 8, with the exception of the year 1969 which is an interpolation and the year 1970 which is the U.S. Census figure.

[2] Total nonfederal physicians in Pennsylvania figures for the years 1906 to 1960 were obtained from *Medical Education in Pennsylvania; Past, Present, Future* (1963) which were derived from *AMA Medical Directories* for 1958 and 1961. Figures for the years 1963 to 1970 were obtained from the *Distribution of Physicians* special statistical series published by the Department of Survey Research, Center for Health Services Research and Development of the American Medical Association.

[3] The area of the State of Pennsylvania (45,507 sq. mi.) was obtained from p. 11, Table 7, of the *1970 Pennsylvania Statistical Abstract.*

*(*From "A Study of Physician Manpower Demand and Supply in Pennsylvania, 1973")*

Appendix B	Medical Economics Survey of Specialty Societies (Optimal Ratios)*	1973 Pa. Ratios (Total (Physicians)**
General/ Family Practice	1/2,000	1/3,875
Internal Medicine	1/5,000	1/4,657
Pediatrics	1/10,000	1/12,909
OB-GYN	1/11,000	1/10,838
General Surgery	1/10,000	1/7,715
Ophthalmology	1/20,000	1/19,560
Otolaryngology	1/25,000	1/39,000
Radiology	1/15,000	1/17,182
Anesthesiology	1/15,000	1/19,396
Dermatology	1/50,000	1/54,315
Neurology	1/75,000	1/73,000
Neurosurgery	1/100,000	1/86,790
Plastic Surgery	1/50,000	1/130,659
Psychiatry	1/10,000	1/10,384
Thoracic Surgery	1/100,000	1/127,000
Urology	1/30,000	1/36,811
All Physicians	1/635	1/627

***From "Distribution of Physicians, 1973," AMA*

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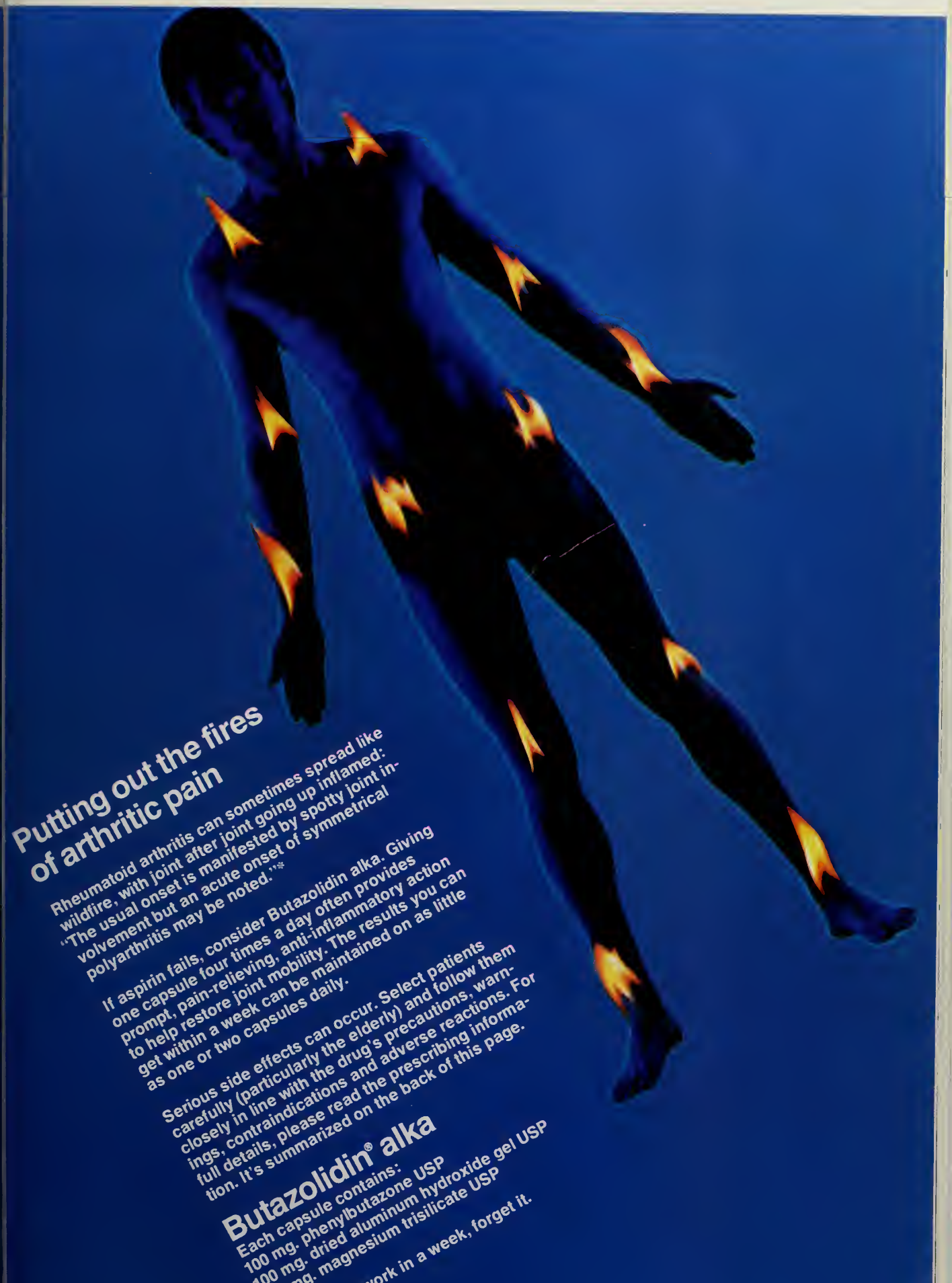


Putting out the fires of arthritic pain

Rheumatoid arthritis can sometimes spread like wildfire, with joint after joint going up inflamed: "The usual onset is manifested by spotty joint involvement but an acute onset of symmetrical polyarthritis may be noted."*

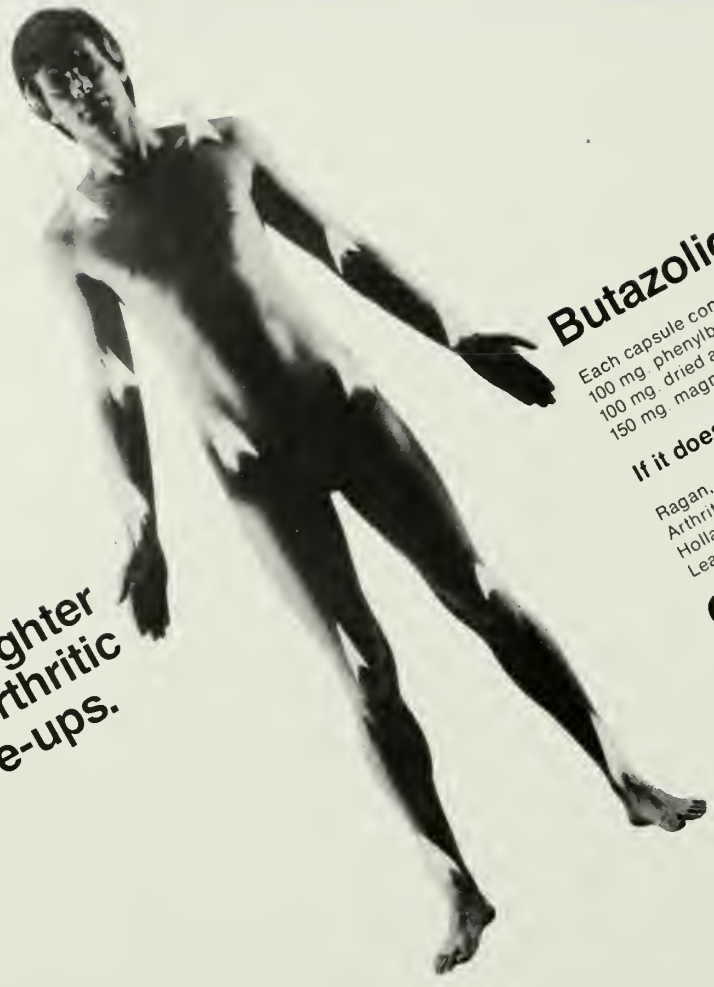
If aspirin fails, consider Butazolidin alka. Giving one capsule four times a day often provides prompt, pain-relieving, anti-inflammatory action to help restore joint mobility. The results you can get within a week can be maintained on as little as one or two capsules daily.

Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions. For full details, please read the prescribing information. It's summarized on the back of this page.

Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.



Fire fighter for arthritic flare-ups.

Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.

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Geigy

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.
Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.
Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh patient's progress dictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, heartburn, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
(B)98-146-070-J (10/71)

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Physicians' assistants—a report of pros and cons

KENNETH B. JONES
Pennsylvania Medical Society

A working definition of the physician's assistant is someone who provides, under the direction and supervision of a licensed physician, evaluative, diagnostic, and therapeutic tasks traditionally performed only by the physician. Within that definition four main types of training for the physician's assistant can be identified:

1. The graduate of the two year physician's assistant program modeled on the original Duke program. Students come with a variety of backgrounds and the didactic portion of the course is fairly long.
2. The graduate of the MEDEX program. Students are generally ex-independent duty corpsmen with considerable military experience in patient care.
3. The graduate of the nurse practitioner program. Students are licensed nurses.
4. The physician's assistant, usually already licensed as a nurse, who has been trained by the physician himself.

For the purposes of this paper, these four categories will be considered collectively, although the categories are not all inclusive and each type of physician's assistant is slightly different from the others.

Physician support

Pro: The physician's assistant concept could not have developed without the support of individual physicians and organized medicine. In each of the physician's assistant programs given above, the credit for the development of prototypical programs goes to the individual physician, sometimes with strong support of state medical societies. The AMA has played a strong leadership role in defining the concept, developing an approval mechanism for physician's assistant programs, and developing a national certification exam for physicians' assistants.

Con: Physicians are far from unanimous in their support of the physician's assistant concept. The Erie County Medical Society has refused to endorse the Hahnemann-Gannon Physician Assistant Program. The Erie County Medical Society gave as its reason for refusal uncertainties as to the legal status of the physician's assistant but clearly there was also strong sentiment against the concept itself. Physicians using assistants have sometimes had difficulty in obtaining medical staff approval to use a physician's assistant in the hospital. In some cases the majority of the medical staff opposed the idea itself.

The federal government has been responsible for the rapid growth in the number of physicians' assistants being trained. Working through the familiar method of providing money, the federal government has financially supported much of the developmental work including preparation of a physician's assistant certifying examination. They now support 40 of the 80 recognized physician's assistant programs at the rate of $6.3 million per year. Both Pennsylvania programs are supported by the federal government.

Need

Pro: The key argument in support of the physician's assistant concept is that the assistant can increase the productivity of the physician and help solve the physician shortage. The main thrust of physician's assistant programs is toward training assistants to the primary care physician in rural and inner city areas. While there is no physician shortage in Pennsylvania, there continues to be a shortage of primary care physicians. This argument for physicians' assistants is still a valid one.

The addition of a physician's assistant to an office practice can result in the substantial increase in the number of patients the practice can see. An increase within the 30 to 70 percent range can be expected.

Con: Those arguments ignore the mixed success of physician's assistant programs in placing assistants in

areas of greatest need. The same factors that influence physicians to practice in the suburbs also influence physicians' assistants. Increases in the number of physicians' assistants may mean little in terms of improvement in the quantity of services available in areas of greatest need.

The primary care physician shortage is already being solved. The recognition of the specialty of family practice, the rapid increase in the number of family practice residencies, the increase in medical student interest in primary care, and the introduction of supportive legislation at the state and federal level all point toward considerable progress. Physicians' assistants, while they may be needed now, may not be needed in the immediate future. Concentration should be on solving the primary care physician shortage.

Quality of patient care

Pro: There is adequate justification for the physician's assistant concept even if there were no physician shortage. Parts of the practice of medicine simply don't require a physician's training. Physicians have traditionally delegated certain tasks, finding that the best use of their time and the most efficient way to practice.

Because the assistant sees the routine cases, the physician can concentrate on those cases which require his training. The physician's assistant, because he has limited responsibilities in fairly uncomplicated tasks, becomes proficient in those limited tasks, perhaps more proficient than the physician. The physician determines exactly what tasks the assistant is competent to perform; physician supervision and responsibility help ensure quality care.

Patients also receive better care because they receive more care. For example, an assistant may make "rounds" in the hospital in the morning with the physician making them in the afternoon. Without the assistant, only the afternoon rounds are made.

Con: The trend in all aspects of medical care has been to require higher, not lower, qualifications. A task analysis may indicate that less well-trained personnel could perform the tasks, but such analysis ignores the issues of judgement and the "unusual" case.

The supervision issue is also cause for concern. This is discussed in terms of a possible long-term erosion of the supervision principle later in the paper. Even if no such erosion occurs. some serious questions remain. The closer the supervision of the assistant, the fewer patients the practice will see. Pressure then is for less optimal supervision. Both the physician and the assistant must recognize the physician's assistant's limitations. The possibility that the physician will delegate too much or that the assistant will not recognize his limitations are real ones. The dangers increase in proportion to the amount of time the assistant is remote from the physician. As the physician's assistant concept becomes more established with both the public and the profession, the danger of misuse increases.

These concerns could be answered by a detailed definition of supervision. For example, supervision could be defined to require the personal presence of the physician or to require the physician to see every patient on each office visit or to require the use of approved protocols. Each of these attempts to strictly define supervision limits the physician's ability to organize his practice in the best manner for him and his patients.

Depending on the form legislation in Pennsylvania takes, health care facilities may be allowed to employ physicians' assistants. The assistant will be under the supervision of a physician but the relationship will be less defined than when the physician is the employer. The tendency for health care institutions may be toward replacing physicians with more or less independent physicians' assistants.

Relationship to physicians

Pro: Acceptance by the public and the medical profession of the physician's assistant concept has been based on the dependent role of the physician's assistant. The danger to quality medical care lies not with dependent allied medical personnel but with the erosion of medical practice by independently licensed groups. Because of the close working relationship with the physician, the assistant is better supervised than many existing allied medical groups performing important technical tasks.

The dependent status of the physician's assistant has universal acceptance; legislation to regulate physicians' assistants has recognized this principle. State medical boards are given key roles in drafting rules and regulations.

Con: These arguments ignore the probable trend for the future. As physicians' assistants become firmly established, physicians' assistants may seek to be removed from the control of medical boards and then to establish parameters of independent practice.

Economics

Pro: Physicians have an economic incentive to use physicians' assistants. Experiences differ but in general the increased productivity through the use of assistants is not offset by increases in cost. The physician can decide to lower his fees for some services, thereby reducing the cost of medical care without any financial sacrifice. The American Medical Association has adopted a strong position that the payment by third parties should be for services, no matter who under the physician's supervision delivers them.

Con: Over the long term, third parties will exert pressure to reduce payment for physician's assistant services to below that of physicians' services. Blue Shield, for example, in a pilot study is, with the agreement of participating physicians, reimbursing physician's assistant services at a lower rate. Under these circumstances fees for certain procedures may tend downward; fees in general could even be affected. The physician without an assistant would find himself at an economic disadvantage and under economic pressure to hire an assistant.

Treatment of carcinoma of the prostate

Comparison between single and multiple drug therapy

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Treatment of patients with advanced prostatic carcinoma in whom orchiectomy and estrogen treatment fail to control progression of the disease has resulted in limited success.[1,2] None of the available chemotherapeutic agents has shown a significant advantage in either palliation or survival. An earlier series of thirty-seven patients was reviewed at the Northeastern Section Meeting of the American Urological Association in 1970. It was felt, then, that the use of 5-fluorouracil® (Roche Laboratories) in combination with an alkylating agent, might be more effective than single drug therapy.[3] The present series was begun at that time to compare the combination with single alkylating agents in patients with metastatic prostatic carcinoma.

Material and methods

The study was restricted to those patients in whom advanced, progressing prostatic carcinoma was present with proven metastatic disease. Bone x-rays or scans were positive for osseous metastases and the serum acid phosphatase exceeded 2.0 mU/ml. In each case, previous estrogen therapy had not significantly affected progression of the disease or was no longer effective. Virtually all were asymptomatic. In thirty-four patients, initial therapy was begun with cyclophosphamide, intravenously, 7-10 mg/Kg daily for five days or Thiotepa® (Lederle Laboratories) intravenously, 0.6-1.2 mg/Kg daily for three days. Until the white blood cell count fell below 4000 WBC/cmm, the drug was repeated every third day. When a leukopenia of less than 3000 WBC/cmm occurred, the drug was discontinued. Oral cyclophosphamide was given at monthly intervals to maintain a mild leukopenia during progression of the disease.

Fifteen patients were begun, initially, on 5-fluorouracil, 7.5-12.0 mg/Kg daily for three to five days, followed by the intravenous administration of the alkylating agent in appropriately lower amounts. Maintenance therapy in this group was with 5-fluorouracil monthly and reduced amounts of cyclophosphamide, again, during the periods of clinically progressive disease.

Supportive measures, including blood transfusions and antibiotics, were carried out as necessary. Facilities for isolation were limited, but infected contacts were discouraged.

The treatment mortality included patients dying as a direct affect of the drugs, as well as subsequent deaths due to blood transfusions required during therapy.

TABLE I

Drugs	Alkylating Agent	Alkylating Agent and 5-Fluorouracil
Usual Dose	**Initial Treatment** Cyclophosphamide IV 500mg/daily x5 or Thiotepa IV 50 mg/daily x3 Then every 3rd day until Leukopenia noted. **Maintenance Treatment—** cyclophosphamide.	**Initial Treatment** 5-fluorouracil 8-10 mg/kg. IV daily x3 followed by a decreased dose of Thiotepa or cyclophosphamide **Maintenance—**oral cyclophosphamide and 5 FU monthly IV
Patients	Ages 34 (51-82)	Ages 15 (53-82)
Acid Phosphatase decrease greater than 30%	23 (68%)	9 (60%)
Tumor Regression greater thru 50%	21 (62%)	7 (47%)
Leukopenia below 2500 white count	13 (39%)	4 (27%)
Mortality due to Therapy	3 (9%) Septicemia-2 Serum Hepatitis-1	3 (20%) Septicemia-1 Refractory Leukopenia-1 Serum Hepatitis-1
Average Survival	11.1 Months	10.5 Months

Results

Tumor response was similar in the two groups (Table I). An associated decrease in the serum acid

TABLE II

	Complications of Therapy	
	Drugs	
	Alkylating Agent (Cyclophosphamide-Thiotepa)	Alkylating Agent and 5-Fluorouracil
No. of Patients	34	15
Refractory Leukopenia	—	1
Bleeding -		
Skin Ecchymosis	8	3
G I Bleeding	1	4
Hemorrhagic Cystitis	3	—
G I Glossitis and Stomatitis		4
Diarrhea	2	2
Septicemea with Pneumonitis	4	2
Serum Hepatitis	1	1
Anemia (below 7.5 gm)	13	8
Alopecia	23	3

phosphatase was evident, and the difference was not statistically significant. However, the absence of a significant fall in the acid phosphatase was associated with a poor response to therapy.

A leukopenia of 2500 WBC/cmm or less during the initial course was frequently associated with the more marked tumor responses.

Following initial therapy, relief of pain lasting two to ten months occurred in two-thirds of the patients in each group.

Complications were more acute, and generally more serious in patients on combination therapy (Table II). Gastrointestinal symptoms, including significant blood loss limited therapy in four patients on 5-fluorouracil. While many patients had reduced hemoglobin levels at the onset of therapy, a further decline (below 7.5 Gm) required that blood transfusions be given to almost half of each treatment group. Alopecia was recorded in two-thirds of patients receiving alkylating agents alone, reflecting the duration and amount of cyclophosphamide in this group. Hemorrhagic cystitis was seen in three patients receiving cyclophosphamide in high doses.

Treatment mortalities included three patients in each group and suggest the greater risk of combined therapy in this series. Survival in both groups averaged slightly less than one year.

Discussion

Using the drugs in the regimen outlined, the results obtained, as well as the complications noted, were similar to most reported series.[4-8] No improvement was demonstrated by combined therapy using 5-fluorouracil with an alkylating agent either in the initial response or in average survival rate. However, a greater risk of treatment morbidity and mortality does appear to occur with multiple drug therapy.

No available agent has been shown to result in better initial improvement of longterm survival than the alkylating agents alone.[9,10] Therefore, until a more specific drug is developed, the use of a single drug would be expected to result in fewer serious problems during this already difficult period in the disease.

Conclusions

The alkylating agents, cyclophosphamide and Thiotepa, result in remission in approximately two-thirds of patients with progressive, metastatic carcinoma of the prostate.

The combined use of these alkylating agents and 5-fluorouracil result in a similar response, without any apparent advantage.

In this series, morbidity and treatment mortality were increased in the group receiving combined therapy. □

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Subclinical lead burden: Relation to hemoglobin and hematocrit values

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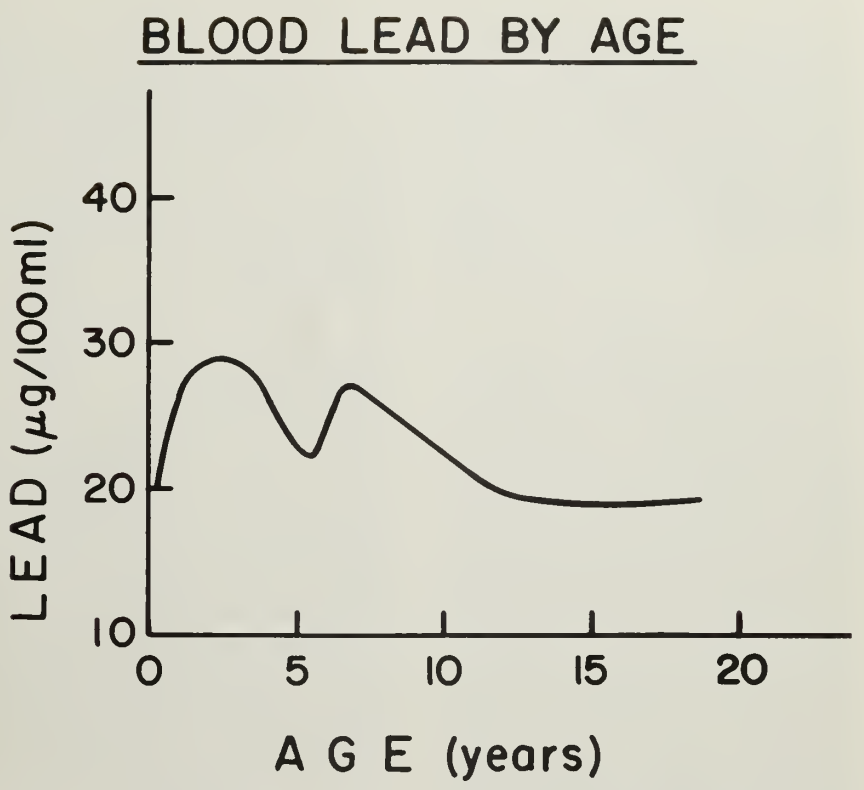

Figure 1. Mean blood lead with two peaks. The highest peak was in the 1-3-year-olds. A slightly lower peak is shown in the 6-year-olds.

A BLOOD lead level over 80 ug per 100 ml of blood has been found in 2 to 8 percent of young, urban ghetto children[1,12,15,17] and levels of 40-80 ug per 100 ml of blood in 15 to 31 percent of these children.[1,9,10,17] Much is known about the devastating effects of lead poisoning. It is known to interfere with normal human metabolic processes,[4,7] and its association with severe anemia is well documented.[18,19] Its effect on the intellectual functioning of affected children has also been recognized.[3,12,16]

TABLE I

Profile of the Study Population by Age Groups

Age (yrs.)	No. Screened	Males	Females	No. excluded for anemia alone	No. excluded for Blood Lead 50 ug% alone	No. excluded for both	Total No. Excluded	No. included in analysis
1	70	38	32	17 (24%)	0	0	17 (24%)	53
1-3	329	163	166	46 (14%)	18 (5%)	7 (2%)	71 (21%)	258
4-9	459	215	244	47 (10%)	9 (2%)	7 (1.5%)	63 (13.5%)	396
10-13	438	218	220	40 (9%)	8 (2%)	4 (1%)	52 (12%)	386
14-18	263	107	156	65 (24.5%)	5 (2%)	1 (0.5%)	71 (27%)	192
Totals	1559	741	818	215 (13.8%)	40 (2.5%)	19 (1.1%)	274 (17.5%)	1285 (82.5%)

Little is known about the effects of lead burden associated with blood lead below 80 ug per 100 ml of blood, and there is some disagreement about the little that is known. Peuschel et al,[17] for example, demonstrated an inverse relationship between the hemoglobin values and blood lead levels of one to six-year-old urban children in Boston. In contrast, Lubin et al,[9] failed to find any relationship between the hemoglobin levels and blood lead levels in a group of similar aged children from Columbus, Ohio. Perlstein and Attala,[16] de la Burde and Choate,[5] and Needleman[14] have recently called attention to the neurological implications of widespread subclinical lead intoxication in children. Kotok,[8] on the other hand, could find no evidence of neurological damage attributable to subclinical lead burden.

There is some debate about whether the child with subclinical lead burden should have his burden therapeutically reduced. It has been shown that when urban children at risk are removed from their lead environment even for as brief a time as two to three months their burden, as measured by blood lead levels, is significantly lower than that of a comparable group of children who remain in their lead environment.[2]

Because lead burden and anemia are very common in urban children, and because the latter frequently results from nutritional deficiencies, an attempt was made in this study to correlate blood lead levels under 50 ug/100 ml of blood with hemoglobin and hematocrit values in a group of urban black children in whom moderate to severe anemia (hemoglobin $<$10.5 Gm percent and/or hematocrit $<$32 percent) has been excluded.

Materials and methods

Each of 1,559 black urban children aged six months to eighteen years (Table I) at routine physical examination had a complete blood count (CBC), including hemoglobin and hematocrit performed with the Coulter S machine. Blood lead was determined by the method of Farrelly and Pybus[6] and G6PD screening by the semi-quantitative method of Motulsky and Campbell-Kraut.[13] All children with an Hgb of 10.5 Gm percent or less and/or Hct of 32 percent or less and those with blood lead over 50 ug per 100 ml of blood were excluded from analysis. A nutrition history including information about pica was obtained from all patients.

TABLE II

Mean Blood Lead, Hgb & Hct by G6PD Status in 1-3-year-olds

Total	*N*	*Blood Lead (ug/100 ml of blood)*	*Hgb (Gm%)*	*Hct (%)*
Total Group	*263*	*29.1 ± 14.5*	*11.8 ± 0.8*	*36.1 ± 2.1*
AA-G6PD normal	*190*	*30.0 ± 14.8*	*11.9 ± 0.9*	*36.3 ± 2.2*
AA-G6PD deficient	*27*	*33.0 ± 15.1*	*12.0 ± 0.9*	*36.5 ± 2.4*
AS-G6PD normal	*42*	*29.0 ± 13.9*	*11.6 ± 0.8*	*36.0 ± 2.0*
AS-G6PD deficient	*4*	*33.0 ± 4.9*	*12.1 ± 0.9*	*36.7 ± 2.3*

Results

Nine parents admitted to pica in their children, and all of these children had blood lead over 50 ug per 100 ml of blood and were thus excluded from analysis.

Seventeen percent of the children were excluded from analysis because of the presence of either moderate/severe anemia (Hgb $<$10.5 Gm percent and/or Hct $<$32 percent) or blood lead over 50 ug per 100 ml of whole blood. Over three quarters of those excluded were excluded because of anemia alone. About one seventh of the exclusions were because the blood lead level was over 50 ug per 100 ml (Table I).

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Mean blood lead value for the entire population was 23.7 ug per 100 ml of blood. However, mean blood lead values varied significantly at different ages (Fig. 1). The highest peak (29.1 ug per 100 ml of blood) was found in the one to three-year-old group and the next highest peak in the six-year-old group (28.1 ug per 100 ml of blood). After six years of age, the level declined steadily with age and stabilized at 20 ug per 100 ml of blood after ten years of age. There was no difference in the mean values of Hgb, Hct, or blood lead content due to sex, G6PD status, or the presence or absence of Hemoglobin S (Table II).

In children under one year of age, the mean Hgb (11.8 Gm percent) and Hct (35.2 percent) were not influenced by the blood lead levels within the narrow range, 0-25 ug per 100 ml of blood, encountered in these children. In the ten to eighteen-year-old group, there was no correlation between the mean blood lead levels from 0-50 ug per 100 ml of blood and the Hgb and Hct values. In the four to nine-year-old boys (but not girls), there was a slight inverse relationship between the blood lead levels, from 0-50 ug per 100 ml and the Hgb and Hct values (Fig. 2).

In the one to three-year-old group of both sexes (Fig. 2), a rather significant inverse relationship was found between the blood lead values, from 0-50 ug per 100 ml of blood and the Hgb and Hct values ($r = -0.53$ $N = 129$ $p < 0.001$ for Hgb vs blood lead in boys and $r = -0.31$ $N = 135$ $p < 0.001$ for Hgb vs blood lead in girls).

Discussion

In a paper by Peuschel et al,[17] one of the most striking graphs showed an inverse relationship between blood lead levels and Hgb values in a group of one to six-year-old Boston children. The findings in this study agree with this observation and contrast with the findings of Lubin et al,[6] who found no relationship between Hgb values and blood lead values. In this study, there was no correlation between blood lead values and Hgb or Hct values in children over four years of age or in those under one year of age.

Two peaks of blood lead was found, one at one to three years of age and a second at six years of age. There was no apparent explanation for the second peak. It is noteworthy that there was no correlation between the blood lead values and Hgb or Hct values in these six year olds.

This study fails to confirm the findings of McIntyre and Angle[11] who found higher lead values in the red cells and whole blood of G6PD deficients compared with their non-deficient classmates. The G6PD status of the children in this study did not appear to have influenced the blood lead levels and the Hgb or Hct values.

The nutritional status of the children in this study was generally good, although anemia was common. Children with blood lead levels in the lower ranges (0-50 ug per 100 ml of blood) rarely manifest striking physical findings. The inverse relationship between blood lead levels and Hgb and Hct values found in children in this and other studies[17] suggest that there may be deleterious effects associated with blood lead levels usually thought to be "safe." The young urban child between one and three years of age, a period marked by rapid growth and development and maximum lead exposure appears to be most vulnerable and could well have paid a damaging price long before he acquires enough lead to have a toxic effect. □

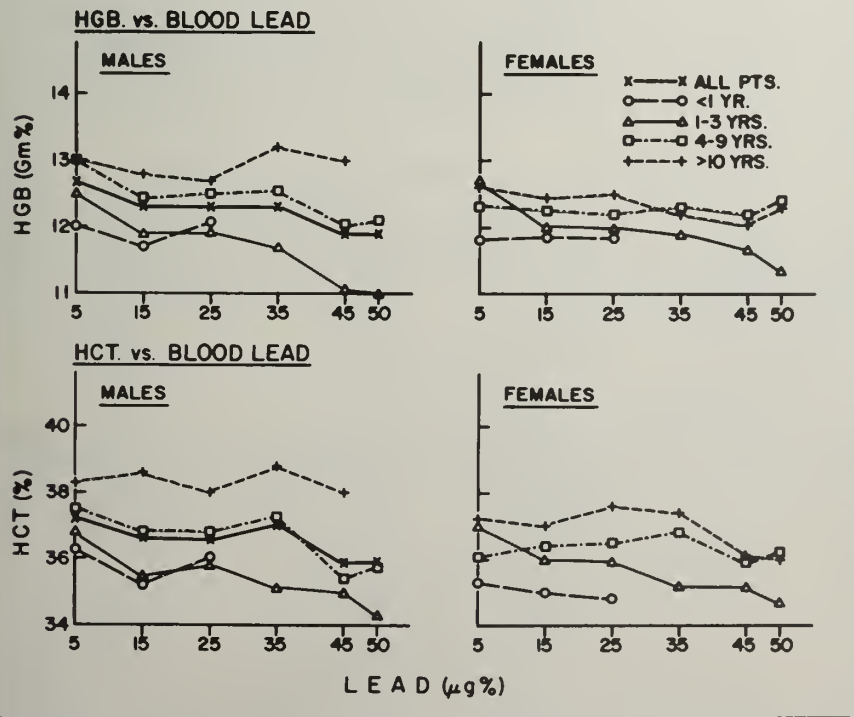

Figure 2. Mean Hgb and Hct by age at different blood lead levels. Children with overt anemia (Hct < 10.5 Gm% and Hct < 32%) have been excluded from this analysis. Note the progressive decrease in Hgb and Hct values with increasing blood lead levels in the 1-3-year-olds of both sexes but not in the children of other ages.

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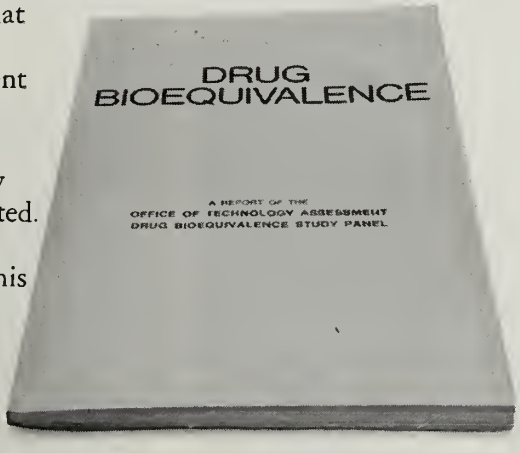

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Emergency Room Physician—to join four man group. 325 bed hospital with complete specialty backup. Endless Mountain region of northeastern Pennsylvania. Excellent compensation and benefits. Apply to Department 660, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, Pa. 17043.

GP/FP—Community Memorial Hospital based group wants physician to join 4-man group. 42 hour week, paid malpractice, 4 weeks vacation, 3 weeks education. Near Philadelphia, Wilmington, Baltimore, seashore. Call (215) 869-2431, Dr. Kenna or administrator, West Grove, Pa.

The Frankford Hospital of Philadelphia is currently expanding its medical staff to accommodate the development of a second division to be located in the rapidly growing Far Northeast section of the city. Primary physicians, including obstetricians, interested in locating in this area should call Ronald E. Cohn, M. D., Medical Director, (215) 831-2000 or write 4940 Frankford Avenue, Philadelphia, Pa. 19124.

Medical Director—Pa. licensed. Modern JCAH accredited 250 bed hospital with modern facilities. Medical and dental staff of 85. Central Pa. location near major university. Excellent financial and fringe benefits. Contact Thomas F. Grimes, III, Administrator, Lewistown Hospital, Lewistown, Pa. 17044.

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Director of Clinical Laboratory—147 Bed Acute Care Community Hospital located in Philadelphia suburbs has full time position available for Board Certified (APCP) Pathologist. Growing community of over 80,000 with hospital admissions exceeding 7,000 last year and an annual growth rate of 6-8% anticipated. Imminent construction of new laboratory planned. Salary negotiable. Reply to: Robert H. McKay, Executive Vice President, North Penn Hospital, 7th and Broad Streets, Lansdale, Pa. 19446, telephone (215) 368-2100.

Board Eligible Internist—wanted for small community hospital. Duties include outpatient services as well as inpatient services and consultations. Guaranteed minimum salary $35,000 plus benefits. Write Department 659, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, Pa. 17043.

Coatesville, Pa. Physicians needed (Family Practice, Internists, Psychiatrists) to work in accredited Veterans Administration Hospital, 38 miles west of Philadelphia. Affiliated with the Jefferson Medical College, Thomas Jefferson University, Philadelphia, Pa. License any state. Salary range $25,581 to $34,788. Commensurate with training and experience. Excellent fringe benefits. Contact Chief of Staff, VA Hospital, Coatesville, Pa. 19320. Nondiscrimination in employment.

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obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Joseph A. D'Alessandro,** Girardville; Georgetown University School of Medicine, 1936; age 65; died January 7, 1975. He is survived by a sister and a niece.

• **Eugene J. Gallagher,** Glenside; Jefferson Medical College, 1948; age 50; died December 29, 1974. Dr. Gallagher was athletic physician and acting director of Student Health Services at La Salle College. He was a fellow of the American College of Sports Medicine. Surviving are his wife, a son, a daughter, his father, and a brother.

• **Harry S. Hutchison,** West Alexander; Western Reserve University School of Medicine, 1920; age 82; died December 18, 1974. Dr. Hutchison was a fellow of the American College of Surgeons and had received a fifty year certificate from the Pennsylvania Medical Society. He is survived by his wife, a son, two daughters, a brother and sister.

• **John J. Knox,** Gettysburg; University of Maryland School of Medicine, 1938; age 63; died December 21, 1974. Dr. Knox was awarded the Legion of Merit during World War II. Information regarding survivors is not available.

• **Erling N. Larsen,** DuBois; Rush Medical College, 1926; age 75; died December 15, 1974. Dr. Larsen was past president of the Clearfield County Medical Society, a member of the Radiological Society of North America, Pennsylvania Society of Clinical Pathology, and Pennsylvania Society of Blood Banks. His son, James Larsen, M. D., and a sister survive him.

• **Vincent J. Mulvehill,** Carrolltown; University of Pittsburgh School of Medicine, 1908; age 96; died December 11, 1974. Several nieces and nephews survive him.

• **Warren N. Shuman,** Jersey Shore; University of Pennsylvania School of Medicine, 1909; age 96; died January 2, 1975. There are no immediate survivors.

• **Effie Claire Thornton,** Jeannette; University of Pennsylvania School of Medicine, 1928; age 77; died December 13, 1974. She was a member of the American Association on Mental Deficiency and on the board of directors of Union County Tuberculosis Society. Surviving are her husband and three daughters.

• **Eugene N. Van Dyke,** Moscow; Johns Hopkins University Medical School, 1920; age 81; died December 26, 1974. Dr. Van Dyke was certified by the American Board of Orthopedic Surgery and taught at Johns Hopkins Medical School and the University of Iowa Medical School. He was a member of the American Academy of Orthopedic Surgeons. A brother, two sisters, and a daughter survive him.

• **Roland F. Wear,** Nescopeck; University of Pennsylvania School of Medicine, 1917; age 81; died December 17, 1974. He was a member of the 30-Year Club of American Medicine and an associate fellow of the American College of Cardiology. His wife, one daughter, and one son survive him.

Francis J. McArdle, Pittsburgh; University of Pittsburgh School of Medicine, 1953; age 51; died December 19, 1974. Dr. McArdle was an associate professor of obstetrics and gynecology at the University of Pittsburgh School of Medicine and a member of the American College of Surgeons and American College of Abdominal Surgeons. He is survived by his wife, a son, and two daughters.

Stanley Rynkiewicz, Kingston; University of Maryland School of Medicine, 1911; age 92; died December 20, 1974. He is survived by a son.

Ruth C. Taggart, Philadelphia; Medical College of Pennsylvania, 1943; age 60; died December 7, 1974. Information regarding survivors is unavailable.

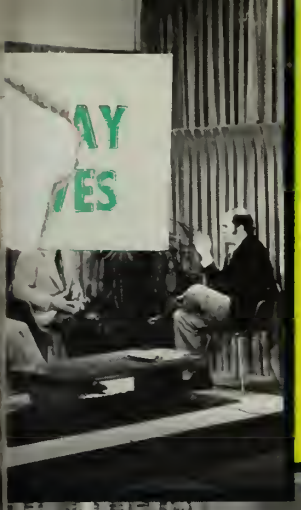
continuing education

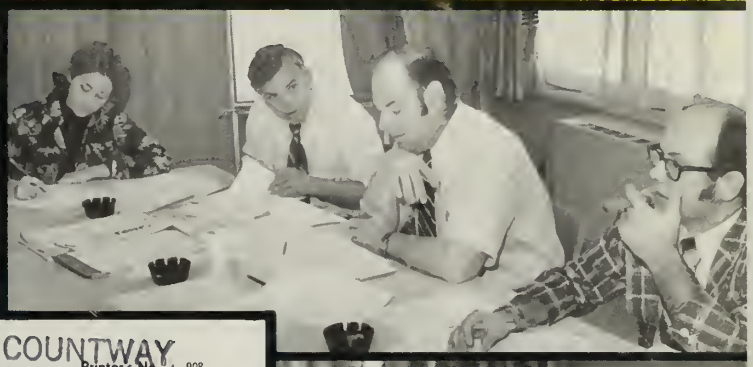
This issue carries no education course listings. The January issue contained a supplement—a comprehensive list of education courses being offered in all parts of Pennsylvania. Consult that issue or write to:

Council on Education and Science
Pennsylvania Medical Society
20 Erford Road
Lemoyne, Pennsylvania 17043

pennsylvania medicine

April 1975





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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 805 Session of 1975

INTRODUCED BY MESSRS. SHANE, SALVATORE, MRS. KELLY, MESSRS. GALLAGHER, HAMMOCK, McCLATCHY, MRS. FAWCETT, MRS. CRAWFORD, MR. HILL, MRS. TOLL AND MR. WAGNER, MARCH 18, 1975

REFERRED TO COMMITTEE ON JUDICIARY, MARCH 19, 1975

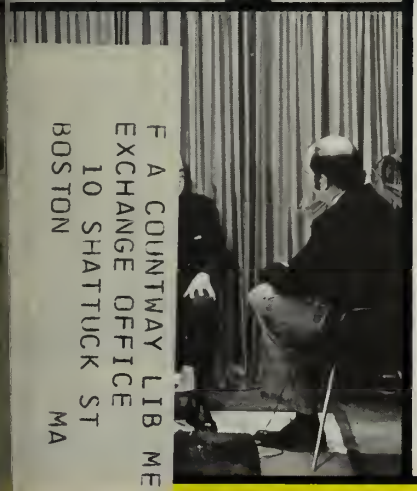
AN ACT

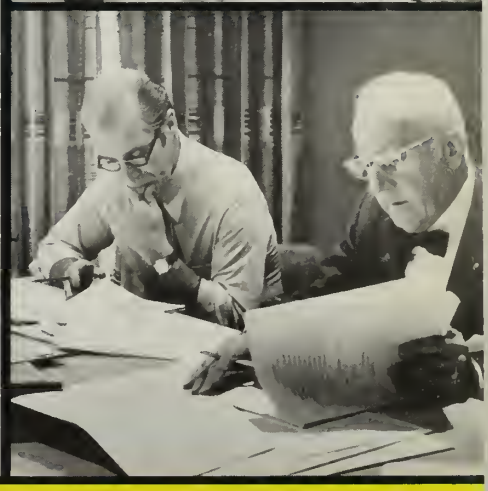
Relating to the promotion of the health, safety and welfare of the people of the Commonwealth by defining medical malpractice, prohibiting medical treatment without consent, creating a Patients Compensation Board and providing for recovery for malpractice, requiring proof of insurance coverage, establishing the period of limitations for malpractice suits, providing for counterclaims, limiting discovery and establishing standards for witnesses in malpractice cases.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short Title.--This act shall be known and may be cited as the "Pennsylvania Medical Malpractice Reform and Patient Compensation Act."

Section 2. Findings and Policy.--It is hereby determined and





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..PRACTICE CRISIS ACTION

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Special malpractice package includes H.B. 805—page 77
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pennsylvania medicine

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APRIL 1975 VOLUME 78, NUMBER 4

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medigram

SHEPPARD ORDERS AMPLE TERMINATION NOTICE

Insurance Commissioner William J. Sheppard has ordered all medical malpractice insurance carriers operating in Pennsylvania to "give this department, your agent, and your professional medical liability insureds--doctor, nurse, and hospital alike--not less than 45 days advance written notice of cancellation or non-renewal." The order appeared in the Pennsylvania Bulletin dated March 29, and resulted from testimony at the department's malpractice hearings in Philadelphia March 18-20 which indicated underwriters were cancelling and issuing non-renewal notices as late as a week before the expiration date on the policy. At the hearings Society President A. Reynolds Crane, M.D., presented the Society's official position on the malpractice crisis (see the complete text on page 102) including announcing the introduction of the Society's remedial legislation which appears in its complete form with a list of original sponsors on page 77.

In the first two days of hearings the insurance commissioner heard testimony from consumers, physicians, lawyers, and insurance industry representatives, including Max H. Parrott, M.D., president elect of the AMA, and Jerrold V. Jerome, Argonaut Insurance Co. president, whose testimony was sharply questioned with regard to its credibility by Commissioner Sheppard. See page 7 of this issue for details on the hearings and the court stipulation under which Argonaut is continuing to write professional liability insurance in Pennsylvania.

COOPERATIVE BOARD MEETING RESET

The first meeting of the Board of Directors of the Pennsylvania Medical Cooperative has been rescheduled from March 22 to April 19 so that bylaws changes mandated by the Society's Board of Trustees providing closer ties with the State Society could be written.

WORKMEN'S COMPENSATION INSURANCE DIVIDENDS DUE

Physicians who have workmen's compensation insurance with the Dodson Insurance Group, the Society endorsed program, will be visited by Casualty Reciprocal Exchange auditors during the next 60 days to compute earned savings for 1974. As soon as calculations are completed dividend checks will be mailed.

UR REVIEW REGULATIONS DELAYED TO JULY 1

HEW Secretary Caspar W. Weinberger has postponed the effective date for implementation of medicare and medicaid utilization review regulations until July 1, 1975 rather than

February 1, 1975 when they were to have become effective for hospitals and other health care facilities. See page 13 of the January issue of PENNSYLVANIA MEDICINE for details. The delay was ordered to give hospitals, especially small, rural facilities, time to come into compliance and avoid loss of eligibility to participate in these programs.

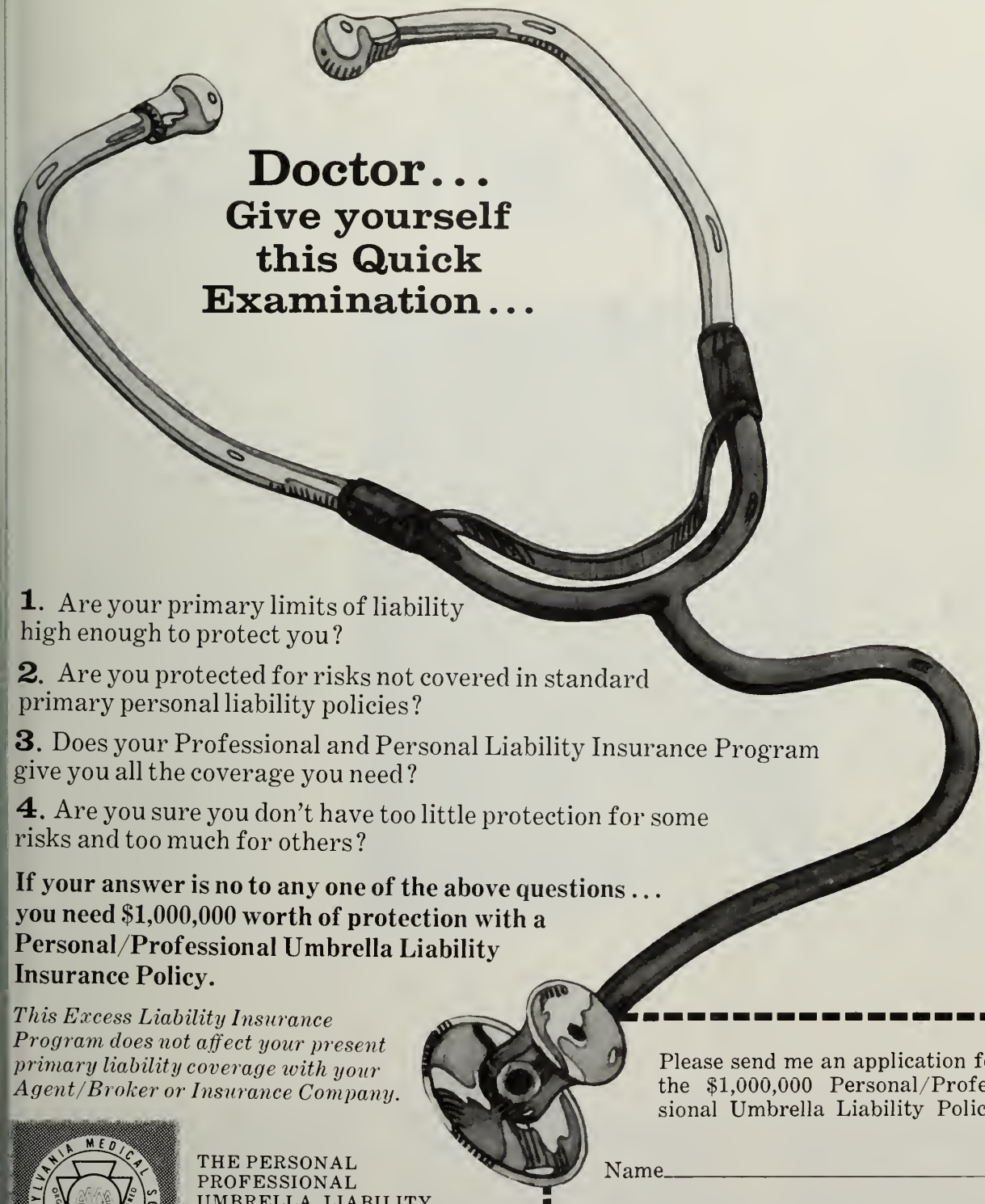
STATE CHP AGENCY SETS HEARINGS The state Comprehensive Health Planning "A" Agency will conduct hearings on May 6 in Hershey. The State Society plans to present testimony. Although not designed for that purpose, the hearings will permit comments on the new health planning act, P.L. 93-641. See the February and March issues of PENNSYLVANIA MEDICINE for the main provisions of the legislation.

BOARD OF TRUSTEES APPROVES DR. HAYES A. Reynolds Crane, M.D. Society president, has appointed Arthur H. Hayes, Jr., M.D., chief of clinical pharmacology at Hershey Medical Center, to the Council on Education and Science. Dr. Hayes will serve as chairman of the Society's new Commission on Therapeutics.

SOCIETY HAS TOLL FREE HOTLINE The WATS line authorized by the 1974 House of Delegates is now installed at Society Headquarters. The line is in operation from 8 a.m. to 4 p.m. Mondays through Fridays. Dial 800-932-0645.

JOINT ACTION EXTENDED TO MALPRACTICE The Hospital Association of Pennsylvania and the State Society will act jointly in efforts on the malpractice crisis following action taken March 12 by the Society's Board of Trustees and earlier by HAP. Ben Badman, Jr., chairman of HAP's Board of Directors, announced that Clyde Waxman, vice chairman of HAP's board, will serve on the Society's ad hoc committee on medical malpractice. HAP has sent a resolution to the American Hospital Association urging that it work jointly with the AMA in the same manner. The State Society's Board of Trustees adopted a resolution to be directed to the AMA along the same lines.

PHYSICIAN'S ASSISTANT LEGISLATION INTRODUCED Senator W. Louis Coppersmith has introduced S.B. 306, an amendment to the Medical Practice Act of 1974 which would give the State Board of Medical Education and Licensure the authority to supervise physicians' assistants. The bill also would authorize the board to oversee the training programs for assistants. The board would have authority to regulate the use of physicians' assistants by individual doctors, groups of doctors, and hospitals. The bill is identical to the final version of the 1974 legislation which passed in the Senate but was not acted on in the House of Representatives prior to adjournment. Committee hearings are expected shortly.



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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Congressman Heinz to speak at Officers' Conference

A major concern of the 1975 Officers' Conference April 23 and 24 at the Host Inn, Harrisburg, will be the State Society's reaction to the professional liability insurance crisis.

A Reynolds Crane, M.D., Society President and keynote speaker, will deliver the "State of the Society" address. Dr. Crane is chairman of the ad hoc committee which is coordinating the Society's response to the crisis.

The Commission on Professional Liability Insurance will sponsor a presentation on the malpractice situation. In addition, Elliot L. Sagall, M.D., medical editor of *TRIAL* magazine, is scheduled to speak on "Malpractice RX." He is expected to present a broader view of what is now a national problem.

Health legislation, a constant concern of the State Society, will be a topic of discussion during the Officers' Conference. During the Thursday morning session, Representative H. John Heinz, III, will speak on "The Shape of National Health Legislation." The Pennsylvania Medical Political Action Committee is expected to provide a look into health legislation in the State.

The first Walter Foster Donaldson Memorial Lecture will be given by nationally known journalist Harry Schwartz, Ph.D. Dr. Schwartz is a member of the New York *Times* editorial board and a professor at the State University of New York, New Platz, New York.

Frank J. Jirka, Jr., M.D., trustee of the American Medical Association, is scheduled to speak during the Wednesday afternoon session. His topic will be "I'm Bullish on the AMA."

The PMS Council on Professional Relations and Services will sponsor "Wanted—PMS Members," a presentation on the Ambassador Program, a membership recruitment project in the Fifth Councilor District. A report of the program's April 10 launch and early stages is expected.

Humorist Irv Wermont will be the dinner speaker Wednesday evening. He has entertained various types of conferences and conventions throughout the country. He has been involved in sales promotion and management for twenty-eight years and is currently public relations director for a large New England corporation.

A segment of the conference, "Keeping up with the Physician's Recognition Award," will include a slide show about continuing medical education and the PRA.

Other highlights of the conference will be greetings from R. William Alexander, M.D., chairman of the Officer's Conference Committee, and "Whither PSRO," sponsored by the Pennsylvania Medical Care Foundation.

In conjunction with the Officers' Conference will be a Speakers and Leadership Training Seminar. It is designed to aid in oral communications skills and carries hour for hour Category I credit towards the PRA. There is no charge for the seminar but because of its individualized design, enrollment is limited to thirty persons. The seminar will begin at 8:00 a.m. April 23 and continue until shortly before the Officers' Conference begins. It will resume the next day at 1:00 p.m.

Other meetings in conjunction with the conference will be held by the Interspecialty Committee, the Pennsylvania Delegation to the AMA, the Committee on Quackery, and the PaMPAC Board of Directors.

The Officers' Conference will begin at 1:00 p.m. Wednesday, April 23 at the Host Inn, Harrisburg, and end Thursday afternoon, April 24.

Treats injured athletes

Temple University's Center for Sports Medicine and Science opened recently to treat injured athletes and conduct research into the causes and possible prevention of sports injuries.

Joseph Torg, M.D., associate professor of orthopedics at Temple's School of Medicine, is the center's director. Theodore Quedenfeld, coordinator of training activities for the university's sports teams, is associate director.

The center will provide specialized care for all injured athletes regardless of age, sex, or professional status. Staff members will also train orthopedic residents and teach medical and allied health students, graduate and undergraduate students, coaches and trainers, and will conduct research into injury prevention and effects of athletic competition on adolescents and younger children. Postgraduate courses will be offered to practicing physicians.

Facilities include a hydrotherapy room, weight training and rehabilitation apparatus, minor surgery room, basic therapy room, and complete diagnostic capabilities.

Practice management session termed success

Residents attending the recent "Establishing Yourself in Medical Practice" workshop named it a great success and urged the sponsors to hold others in the future. The workshop was sponsored by the AMA and the State Society's Council on Education and Science.

The two day workshop was developed by the AMA for the purpose of helping new physicians more easily make the decisions connected with entering into private practice. Instruction was offered by George Conomikes, president of Conomikes Associates, Inc., long experienced in providing practice management programs for medical societies. A limit of 35 residents was set in order that each would receive special attention.

During the first day of the workshop, residents were instructed in possible personnel problems, techniques to use in controlling patient flow, and some physical aspects of the medical office. Second day discussions concerned clinical and financial paperwork, practice setting, and legal problems encountered by a physician in private practice.

Evaluations by the residents proved the workshop to be popular and successful. Residents also urged the sponsors to hold more similar workshops so other residents could take advantage of them.

Because more residents than could be accomodated wished to attend the workshop, another one has been scheduled for May 30 and 31 at the Penn Harris Motor Inn, Harrisburg.

The Council on Education and Science also sponsors a Practice Management Seminar which is designed to assist all physicians in improving the business aspects of medical practice. In the past these seminars have met with a great amount of success. The next Practice Management Seminar is scheduled for May 2 and 3 at the Penn Harris Motor Inn, Harrisburg.

Leif C. Beck, president of Management Consulting for Professionals, Inc., Bala Cynwyd, will head the faculty. Topics for discussion will include office facilities and equipment, fees and fee control, billing and collecting systems, group practice matters, and management of professional corporations.

More information concerning either the Practice Management Seminar or Establishing Yourself in Medical Practice may be obtained by contacting the PMS Council on Education and Science at Society Headquarters.

Radiologists to meet

The Pennsylvania Radiological Society, a chapter of the American College of Radiology, will hold its annual meeting May 15-18 at the Host Corral, Lancaster. The scientific portion of the program will be a refresher course, "Bone: Its Diseases and Treatment."

This program is open and approved for nine credit hours in Category I for the Physician's Recognition Award of the AMA by the Pennsylvania Radiological Society.

Registration is available from Donald N. McCoy, PRS Executive Secretary, 20 Erford Road, Lemoyne, PA 17043.

Tumor clinic meets

The Wainwright Tumor Clinic Association's annual meeting will be held on May 14 in McClellan Hall, Thomas Jefferson University Medical College, Philadelphia. A cancer oriented program will be presented.

Registration will begin at 9:00 a.m. and the program will start at 9:30 and adjourn at 4:00 p.m. There is no registration fee. For more information write Hugh R. Gilmore, Jr., M. D., Executive Secretary, Box 90, Harrisburg, PA 17120, or call (717) 787-7073.

Nutrition seminars announced

The American Heart Association, Pennsylvania Affiliate, and its Chapters are sponsoring five nutrition seminars in mid to late May. A faculty of nutrition specialists will discuss the latest information about hyperlipidemias in adults and children, diet counseling, intervention programs, and school lunch programs.

The dates and locations of the seminars are as follows: May 20, Hershey Convention Center, Hershey; May 21, Split Rock Lodge, Lake Harmony; May 22, Penn Pike Sheraton Inn, Fort Washington; May 28, Holiday House, Monroeville; May 29, Holiday Inn, Meadville. Each program will begin at 9:00 a.m. and conclude at 4:30 p.m.

A $10 registration fee includes the luncheon and materials used during the seminar. Reservations must be made by no later than one week before the seminar.

Additional information and registration forms are available through local Heart Chapters or by contacting Royce Britton, Program Director, American Heart Association, Pennsylvania Affiliate, P.O. Box 2435, Harrisburg, PA 17105.

PaMPAC officers elected at board meeting

Officers of the Pennsylvania Medical Political Action Committee for 1975 are: R. William Alexander, M.D., chairman; Charles K. Zug, III, M.D., vice chairman; Paul F. Kase, M.D., treasurer; Mrs. Robert Christman, secretary.

PaMPAC board members at large, elected at a recent board meeting, are: James W. Dunn, M.D., Drexel Hill; Theodore C. Nelson, M.D., Pittsburgh; Paul M. Lin, M.D., Jenkintown; John W. Robertson, M.D., Philadelphia; Joseph S. Silverman, M.D., Altoona.

The names of other members of the PaMPAC board of directors appeared in the March issue of PENNSYLVANIA MEDICINE.

SURROUNDED by a group of Philadelphia school children dressed in costumes of the period of the American Revolution are Robert E. Jones, M.D., of Philadelphia and Governor Milton J. Shapp. Dr. Jones is chairman of the Benjamin Rush House Committee which has as its Bicentennial goal the restoration of the birthplace of the famous physician, father of American psychiatry, and signer of the Declaration of Independence. Members of the Pennsylvania Medical Society will receive letters at the end of this month explaining the project which the State Society has endorsed and asking for contributions to help complete the project.

Unique study session scheduled for October

The Yugoslavian-United States Medical Association is sponsoring its first scientific session, an international medical meeting and tour in Dubrovnik, Yugoslavia, October 26-29. Neoplastic and cardiopulmonary disease is the scheduled topic for the session.

A charter flight will leave Philadelphia October 25 and return November 8. In addition to the scientific session is a choice of three tours: Yugoslavian highlights; sights of Italy, Austria, and Yugoslavia; or Switzerland, Austria, and Yugoslavia.

Cost varies according to the choice of tour and accommodations. Reservation deposits must be made by June 10.

The Yugoslavian-United States Medical Association was formed to promote continuing education, the exchange of scientific knowledge and organizational structuring, and improved international relations. Membership is open to any interested physician.

Information concerning membership application or the scientific session can be obtained by contacting Malcolm Miller, M.D., chairman, Pennsylvania Delegation to the AMA, (215) 649-5226, or the Yugoslavian-United States Medical Association, 2100 Spring Garden Street, Philadelphia, PA 19130.

Doctors found new society

The Central Pennsylvania Neurologic Society recently held its founding meeting at Lancaster General Hospital. The purpose of the new society is to disseminate diagnosis and treatment information among the specialists in neurology and neurosurgery.

Among the society's goals are the establishment of peer review standards, a continuing education program, and clinical presentations of new procedures. The society will also provide the public with information concerning new discoveries in the specialties of neurology and neurosurgery.

Doctors attending the first meeting elected officers and established the framework and bylaws for operation of the new society. James P. Argires, M. D., Lancaster, is president; vice president is Joseph Bittenbender, M. D., Harrisburg. Thomas Stuart, M. D., Lancaster, was elected secretary treasurer.

The Central Pennsylvania Neurologic Society will meet three times a year. The next meeting will be held at Harrisburg Hospital.

Board approves education requirement clarification

The PMS Board of Trustees and Councilors recently approved a procedure by which members may apply for a waiver of the continuing medical education requirement for continued membership in the State Society.

The procedure provides for three basic types of waiver. The *total permanent waiver* is for physicians who are permanently retired. Doctors who are temporarily ill, disabled, or in military service may apply for the *limited time waiver*. The *conditional waiver* is for those who are not able to qualify for the Physician's Recognition Award (PRA) but can provide evidence that they have kept up with areas relating to their work. This conditional waiver applies, for example, when the American Medical Association refuses to accept for the PRA time spent at an outstanding institution which has not applied for accreditation.

Because of a change in the reporting mechanisms proposed by the AMA, State Society members will have an extension of the deadline for accumulating credits. The new deadline is June 30, 1976. The change abandons the concept of a yearly award and provides for acceptance of an application at any time.

The Council on Education and Science is making a concerted effort to assist physicians in obtaining continuing education activities through alternate methods, such as home study courses. They have compiled specific information on the availability of alternate educational methods in various subject areas and maintain listings issued by the University of Wisconsin *(Medical Resource Index)* and the American Medical Association (*JAMA* continuing education supplement). The council has asked the AMA to forward all unacceptable applications submitted by Pennsylvania members for the PRA so the State Society can determine whether or not a conditional waiver is in order for the purposes of the membership requirement.

Because of the extension in the deadline, during this first qualification period the council will consider all members who received the PRA in 1973 or later as having met the membership requirement. In addition, doctors who have met the education requirements of their specialties, provided they are more than or equal to the PRA requirements, will have also met those of the State Society. In many cases, information will be obtained from the various specialty societies, eliminating the need for those doctors to apply to the State Society for the same item.

Waiver applications may be obtained by writing to the Council on Education and Science. In addition to an application, physicians will receive information on alternate means for continuing education. If the physician defines his special educational needs, the council can, in many cases, provide him with useful information.

Because a basic purpose of the continuing medical education requirement is to improve and assist local medical care, applications for waiver should be transmitted through county medical societies which may add pertinent comments. After the State Society receives applications, the council will review them and inform the physicians about their decisions, perhaps suggesting further possible educational activities.

Waiver applications for the continuing medical education requirement for membership and listings of educational activities can be obtained by writing to the PMS Council on Education and Science, 20 Erford Road, Lemoyne, Pa., 17043.

Adjoining state societies meet for education

Physicians have the opportunity to gain Category I credit towards the American Medical Association's Physician's Recognition Award (PRA) by attending the annual meetings of two adjoining state medical associations.

The Medical and Chirurgical Faculty of the State of Maryland is holding its 177th Annual Meeting April 30, May 1 and 2. Among the activities are a scientific program with concurrent sessions cosponsored by the Faculty and various specialty societies, the Lunch and Learn Session including discussions of interest to physicians, educational exhibits, and the Health Evaluation Tests for Physicians.

There is no registration fee and Category I credit for the PRA will be given for attendance. For details write: Medical and Chirurgical Faculty of the State of Maryland, 1211 Cathedral Street, Baltimore, Md. 21201.

The Medical Society of New Jersey is holding its 209th Annual Meeting at the Cherry Hill Convention Area, Garden State Race Track, Cherry Hill, New Jersey, May 31 through June 3. The emphasis will be on continuing medical education subjects that are acceptable to the AMA for PRA credit. The program will include lectures on a variety of useful medical subjects. For specific information write: Medical Society of New Jersey, P.O. Box 904, Trenton, N.J. 08605.

Free medical library services available to physicians

Although PMS support to the Milton S. Hershey Medical Center Library for physicians' inquiries ended February 1, physicians may still receive free library service.

The National Library of Medicine maintains a system by which local hospital libraries may receive stamps to cover the cost of a certain number of inquiries. If physicians channel inquiries through local hospital libraries, they will then contact the medical library in the area: Western Pennsylvania, University of Pittsburgh School of Medicine; Central Pennsylvania, Milton S. Hershey Medical Center; Eastern Pennsylvania, College of Physicians of Philadelphia. The service should then be free of charge.

In order for a hospital to become accredited by the Joint Commission on the Accreditation of Hospitals (JCAH) it must have a medical library that meets JCAH standards, one of which is that "the library shall provide reference service and document delivery service." If the library does not itself have the information to fill a "reasonable request," it must be able to obtain it from another source, in this case, the regional medical library established by the National Library of Medicine.

Insurance Commissioner names new director

Insurance Commissioner William J. Sheppard has announced the appointment of Robert L. Archer as the Insurance Department's new health policy and operations director.

As director, Archer will develop and administer the department's health related policies with specific attention to further cost and quality reforms. One of his responsibilities will be the supervision of the department's regulations for nonprofit Blue Cross and Blue Shield Plans and commercial health insurers.

Archer was formerly director of the Provider Affairs Division of Capital Blue Cross, centered in Harrisburg. He managed Blue Cross' relationships with member hospitals and other medical facilities and was responsible for the firm's health care quality control programs and comprehensive health planning activities.

AMA supports survey

HEW's National Center for Health Statistics is conducting the National Ambulatory Medical Care Survey (NAMCS), a survey of physician contacts with ambulatory patients. The AMA is supporting the survey. The NAMCS objective is to provide basic statistical documentation of the public's use of ambulatory medical services in physicians' offices.

Data in the form of national baseline statistics will describe utilization of ambulatory medical care services in terms of volume of contacts, demographic characteristics of patients, the nature and prevalence of medical problems.

The survey will involve about 3,000 physicians, selected from American Medical Association and American Osteopathic Association master files. Participation involves completing brief forms for about ten patients per day for one week.

Retardation book ready

The American Medical Association has published the second edition of the *Handbook on Mental Retardation.* The updated edition emphasizes new and important areas of knowledge and application. It is not meant to be a textbook, but is intended to provide an overview for practicing physicians, medical students, and laymen interested in problems of mental retardation.

The handbook may be obtained from the Order Handling Department, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610. Costs are: $2.00 a copy for 1 to 10 copies; $1.80 each for 11 to 49 copies; $1.60 each for 50 or more.

Hypertension course set

"New Antihypertensive Drugs," an A. N. Richards Symposium sponsored jointly by the Physiological Society of Philadelphia and the University of Pennsylvania School of Medicine, will be held May 19-20 at Stouffer's Valley Forge Inn, King of Prussia.

The program will deal with the pharmacology and clinical use of new antihypertensive drugs. Topics include epidemiology and pathogenesis, central regulation of arterial pressure, antihypertension activity of diuretics, inhibitors of the sympathetic nervous system, and vasodilators.

The symposium is approved for 14 Category I credits toward the American Medical Association Physician's Recognition Award. The registration fee for the symposium is $35; with dinner and two luncheons the fee is $57. For details contact Dr. Alexander Scriabine, symposium chairman, Merck Institute for Therapeutic Research, West Point, Pa. 19486.

Virus isolated from leukemic cells

National Cancer Institute (NCI) scientists have reported the isolation of a virus from the laboratory grown leukemic cells of a 61-year-old woman with acute myelogenous leukemia. Robert E. Gallagher, M. D., and Robert C. Gallo, M. D., of NCI's Division of Cancer Treatment reported the isolation at a scientific meeting of the American Society of Hematology in December 1974.

The scientists have not yet determined whether the human virus causes acute myelogenous or other leukemias in man. However, they have demonstrated the biochemical and immunologic similarity of the human virus to two viruses that cause cancer in primates other than man. One of these viruses causes myelogenous leukemia in the gibbon ape; the other causes solid tumors in woolly monkeys.

The characteristics of the virus, as determined so far, clearly indicate that it was derived from the human cells. The virus has a core of ribonucleic acid (RNA) and the characteristics of a family of viruses known as type-C. Viruses of this type can cause cancer in a wide variety of animals.

The NCI team isolated the human virus three times from different test tube cultures of the patient's cells. By working with fresh blood samples, the scientists avoided most of the experimental complications associated with growing the cells in the laboratory, contamination with RNA cancer viruses of animals, for example. They believe that the similar but distinct nature of the components in the human leukemic cells is strong evidence that the cells contain an unassembled human RNA virus that may be a factor in causing the disease.

Using various cell culture methods, the scientists mixed the patient's cells in the test tube with growth fluid supplemented with fluid from laboratory grown human embryonic cells. They found that the fluid from the embryonic cells contained a "factor," believed to be a protein, that was essential for growth of the leukemic cells.

After a minimum of five weeks in culture, the leukemic cells began to produce a virus with a core of RNA and the characteristic appearance of the type-C virus. Drs. Gallagher and Gallo then conducted extensive studies of the internal components of the human virus to rule out the possibility of contamination by animal cancer viruses.

They found that the biochemical and immunologic properties of the internal components of the human virus were distinct from those of known animal cancer viruses. In addition, they found that fresh, uncultured leukemic cells from the same patient contained viral components with the same properties as the internal components of the virus in the patient's laboratory grown cells.

Drs. Gallo and Gallagher isolated two viral components from the human adult myelogenous leukemic cells: (1) reverse transcriptase, an enzyme believed essential for RNA viruses to alter deoxyribonucleic acid (DNA); and (2) viral RNA that is bound chemically to the reverse transcriptase. Reverse transcriptase has been found in 50 to 70 percent of the human leukemic cell samples studied.

The scientists indicated that they will concentrate next on determining whether occurence of the human virus is limited to one patient of one type of leukemia, or whether the virus is found in a wider range of patients and leukemias. They also will study whether leukemic patients have antibodies to the virus or its proteins in their blood and whether the antibodies are present at only one point or during the course of the disease.

Critical care meet set

The University Health Center of Pittsburgh will present the Ninth Annual Symposium on Emergency and Critical Care Medicine May 8, 9, and 10 at the Hilton Hotel, Pittsburgh. The international symposium is sponsored by the Society of Critical Care Medicine, the American College of Chest Physicians, and the American College of Emergency Physicians.

The purpose of the symposium is to assist physicians of various disciplines as well as nurse specialists, paramedical and management personnel who wish to improve their effectiveness in the care of critically ill and injured patients. This year's program will review recent advances in the field.

Emergency and Critical Care Medicine is acceptable for 14 ½ credit hours in Category I for the Physician's Recognition Award and the PMS membership requirement. Tuition for the program is $150 for practicing physicians and $100 for nurses, residents, and members of the armed forces.

For complete registration and program information contact William M. Cooper, M.D., Associate Dean for Continuing Medical Education, University of Pittsburgh School of Medicine, 1022-H Scaife Hall, Pittsburgh, PA 15261; (412) 624-2653.

Professional corporation tax issue still unresolved

Controversy over levies on capital stock of M. D. corporations by the Pennsylvania Department of Revenue is continuing. Commonwealth Court has not yet heard the PMS test case (Commonwealth Docket 663, 1974) which appeals an assessment of a professional corporation in Delaware County.

Physician corporations have three options: (1) pay in full; (2) pay under protest while watching the test case and indicate that petition for refund will be made if the verdict is favorable; or (3) refuse to pay and begin an individual appeal.

If the court's decision is favorable to professional corporations, physicians who have paid under protest may petition for refunds. If the verdict is unfavorable, physicians who have chosen the third option must pay the interest and may be penalized. Physicians who choose not to pay are advised to consult an attorney beforehand.

THE SECOND COUNCILOR DISTRICT packed the house at a dinner at the Lehigh Valley Club in Allentown recently to discuss the malpractice issue. In the top photo, left to right, are John F. Rineman, the Society's executive vice president; Leroy A. Gehris, M.D. Second District trustee; A. Reynolds Crane, M.D., Society president; and Leon A. Branton, M.D., of Allentown, president of the Lehigh County Medical Society.

Retraining program planned for May

The Medical College of Pennsylvania is accepting applications for the spring 1975 session of the Retraining Program for Inactive Physicians to be held from May 5 through June 20.

The program provides clinical training for inactive physicians who wish to re-enter clinical medicine by offering review of physical diagnostic skills, experience in clinical rotations, and a lecture series on general medicine, pathophysiology, diagnosis and patient management. To date, the program has retained over seventy women and men physicians; almost all have returned to active medicine, either as residents or practitioners.

For an application and additional information, contact: Nina B. Woodside, M.D., M.P.H., Retraining Program, Center for Women in Medicine, The Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia, PA 19129.

Health post filled

Secretary of Health and Governor's Health Services director Leonard Bachman, M.D., has appointed Buford S. Washington, M.D., of Philadelphia, as commissioner for Regional and Local Health.

In this newly created post, Dr. Washington will assist in the implementation of County Health Department programs, coordinate local health services, and supervise programs in the State Department of Health's four regions.

Dr. Washington has served as chief of professional services and director of the eye department at the Comprehensive Group Health Services Center, Philadelphia. He is also a member of the board of trustees for Philadelphia State Hospital. Professional affiliations include the American Medical Association, Pennsylvania Medical Society, National Opthalmological Association, and the Royal Society of Health, London.

Tape Presentations Medical Arts '74

An Overview of Acupuncture

Check Programs Desired

- ☐ **A105:** Acupuncture: A Therapeutic Modality—Nathan Sussman, M. D., Harrisburg, Pennsylvania. 25 min.
- ☐ **A106:** Acupuncture and Its Role in Anesthesia—James C. Erickson, III, M. D., Professor of Anesthesiology, Jefferson Medical College. 30 min.
- ☐ **A107:** Acupuncture in the Management of Intractable Pain—Mary E. Moore, Ph. D., M. D., Assistant Professor of Medicine, Temple University Health Sciences Center. 20 min.
- ☐ **A108:** Mechanism and Management of Chronic Pain—Jewell L. Osterholm, M. D., Professor of Surgery (Neurosurgery) and Director, Division of Neurosurgery, Hahnemann Medical College and Hospital. 35 min.

The Physician, The Patient and Long-Term Care

- ☐ **A110:** Our Role in the Care of the Aging—Nathan Sussman, M. D., Medical Director, Dauphin County Home and Hospital, discusses the role of medical and allied professions in the care of the aging. 11 min.
- ☐ **A111:** Applied Geriatrics—Joseph T. Freeman, M. D., Philadelphia, Pennsylvania, discusses new circumstances in older age which reassign obligations but do not lessen responsibilities, the need to make judgments in terms of the older person who is living and dying in accordance with new social imperatives, and overtones to life in old age that cannot be judged by rules of survival at all costs. 25 min.
- ☐ **A112:** Commonly Encountered Medical Problems of the Elderly—Thomas Hart, M. D., Consultant and Member of Faculty, Harrisburg Hospital Family Practice Residency Program. 18 min.
- ☐ **A113:** Demonstrating Quality Control—Leslie Fox, Joint Commission on Accreditation of Hospitals, discusses the development of a quality control program in long-term care facilities. 98 min. (Provide Two Cassettes)

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PROLOID® (thyroglobulin)

Caution: Federal law prohibits dispensing without prescription.

Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T_4 and T_3 in Proloid (thyroglobulin) is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, $T_3{}^{131}I$ resin sponge uptake, $T_3{}^{131}I$ red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Instructions for Use. The following conversion table lists the approximate equivalents of other thyroid preparations to Proloid (thyroglobulin) when changing medication from desiccated thyroid, T_4 (sodium levothyroxine), T_3 (sodium liothyronine), or T_4/T_3 (liotrix).

CONVERSION TABLE

Dose of Proloid (thyroglobulin)	Dose of Desiccated Thyroid	Dose of T_4 (sodium levothyroxine)	Dose of T_3 (sodium liothyronine)	Dose of liotrix (T_4/T_3)
1 grain	1 grain	0.1 mg	25 mcg	#1 (60 mcg/15 mcg)
2 grains	2 grains	0.2 mg	50 mcg	#2 (120 mcg/30 mcg)
3 grains	3 grains	0.3 mg	75 mcg	#3 (180 mcg/45 mcg)
4 grains	4 grains	0.4 mg	100 mcg	
5 grains	5 grains	0.5 mg	125 mcg	

In changing from Thyroid USP to Proloid (thyroglobulin), substitute the equivalent dose of Proloid (thyroglobulin). Each patient may still require fine adjustment of dosage because the equivalents are only estimates.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

Supplied. ¼ grain tablets in bottles of 100 (N 0047-0250-51) and 1000 (N 0047-0250-60); ½ grain tablets in bottles of 100 (N 0047-0251-51) and 1000 (N 0047-0251-60); scored 1 grain tablets in bottles of 100 (N 0047-0252-51) and 1000 (N 0047-0252-60); 1½ grain tablets in bottles of 100 (N 0047-0253-51) and 1000 (N 0047-0253-60); scored 2 grain tablets in bottles of 100 (N 0047-0257-51); 3 grain tablets in bottles of 100 (N 0047-0254-51) and 1000 (N 0047-0254-60); scored 5 grain tablets in bottles of 100 (N 0047-0255-51) and 1000 (N 0047-0255-60). Full information is available on request. P-GP-51 4/c

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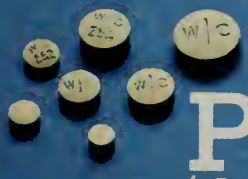

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all the qualities of the "natural" with the added improvements of man...

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natural thyroid...but uniquely purified
Devoid of any glandular debris.

natural thyroid...but triply standardized
Standardized chemically, biologically, and (at intervals) clinically, for consistent metabolic activity from batch to batch.

natural thyroid...but consistently fresh
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It all adds up to natural thyroid with the added improvements of man.

Please see adjoining column for brief summary of prescribing information.

new members

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F. Owen Black, M.D., 230 Lothrop St., Pittsburgh 15213.
Judith Black, M.D., 352 Hunt Rd., Pittsburgh 15238.
Josefina M. Candelaria, M.D., St. Margaret's Mem. Hosp., Pittsburgh 15201.
Fred F. S. Chang, M.D., 1400 Centre Ave., Pittsburgh 15219.
Mary D. Edwards, M.D., 5627 Stanton Ave., Pittsburgh 15219.

BLAIR COUNTY:
Ray Lewis, M.D., Altoona Hosp., Altoona 16603.
John H. Meloy, M.D., Box 39 D-7, R.D. 2, Holidaysburg 16648.

CHESTER COUNTY:
Michael R. Lemert, M.D., 799 Gay St., Phoenixville 19460.
Thomas C. Michaelson, M.D., R.D. 2, Chester Springs 19425.

CRAWFORD COUNTY:
Juanito Domingo, M.D., W. Erie St., Linesville 16424.

CUMBERLAND COUNTY:
Thomas J. Doorly, M.D., 804 Belvedere St., Carlisle 17013.

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Pro-Banthine®
brand of
propantheline bromide

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to: G. D. Searle & Co.
Medical Department, Box 5110, Chicago, Ill. 60680 481

"Antiacid" action for ulcer patients...

one of the many things you need in an anticholinergic.

Pro-Banthine is considered adjunctive in total peptic ulcer therapy that may include diet, conventional antacids, bed rest, and other supportive measures.

Pro-Banthine is provided in several different dosage forms which will meet virtually any clinical need. It is just as versatile in filling patient needs, among which are:

"Antiacid" action—Pro-Banthine® (propantheline bromide) reduces gastric secretory volume and resting total and free acid.

"Analgesic" action—Pro-Banthine helps to control the acid-spasm-pain complex.

Vigorous anticholinergic action—Pro-Banthine® Vials, 30 mg., are for intramuscular or intravenous use when prompt and vigorous anticholinergic action is required.

Mild anticholinergic action—Pro-Banthine® Half Strength, 7.5 mg. tablets, for more exact adjustment of maintenance dosage in mild to moderate gastrointestinal disorders.

Pro-Banthine®
(propantheline bromide)

a good option in peptic ulcer

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NO.4—for pain intensity below the need for injectables

As a rule, only pain that requires morphine is beyond the scope of Empirin® Compound with Codeine No. 4. That's because it delivers a full grain of codeine. (In the preferred phosphate form.) Its antitussive action is particularly appreciated by patients with fractured ribs, and following chest or abdominal surgery. Its low addiction liability is a bonus for all patients who require potent analgesia.

NO.3—for almost all other kinds of lesser pain

Most other kinds of lesser pain respond to Empirin Compound with Codeine No. 3—whether musculoskeletal, neurological, soft-tissue or visceral. One might say No. 3 is an "all-purpose" analgesic — not too little, not too much. Just right for your out-patients in these categories.

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EMPIRIN® COMPOUND C CODEINE

No.3, codeine phosphate*(32.4 mg) gr ½ · No.4, codeine phosphate*(64.8 mg) gr 1

*Warning—may be habit-forming.

Each tablet also contains aspirin gr 3½, phenacetin gr 2½, caffeine gr ½.

KEEP THE HYPERTENSIVE PATIENT ON THERAPY KEEP THERAPY SIMPLE WITH DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Neither inconvenient potassium supplements nor special K^+ rich diets needed as a rule. Just 'Dyazide' once or twice daily for maintenance.

Two prime reasons patients drop out of hypertensive therapy are (1) the patient failed to understand directions, and (2) the regimen was overly complicated. Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

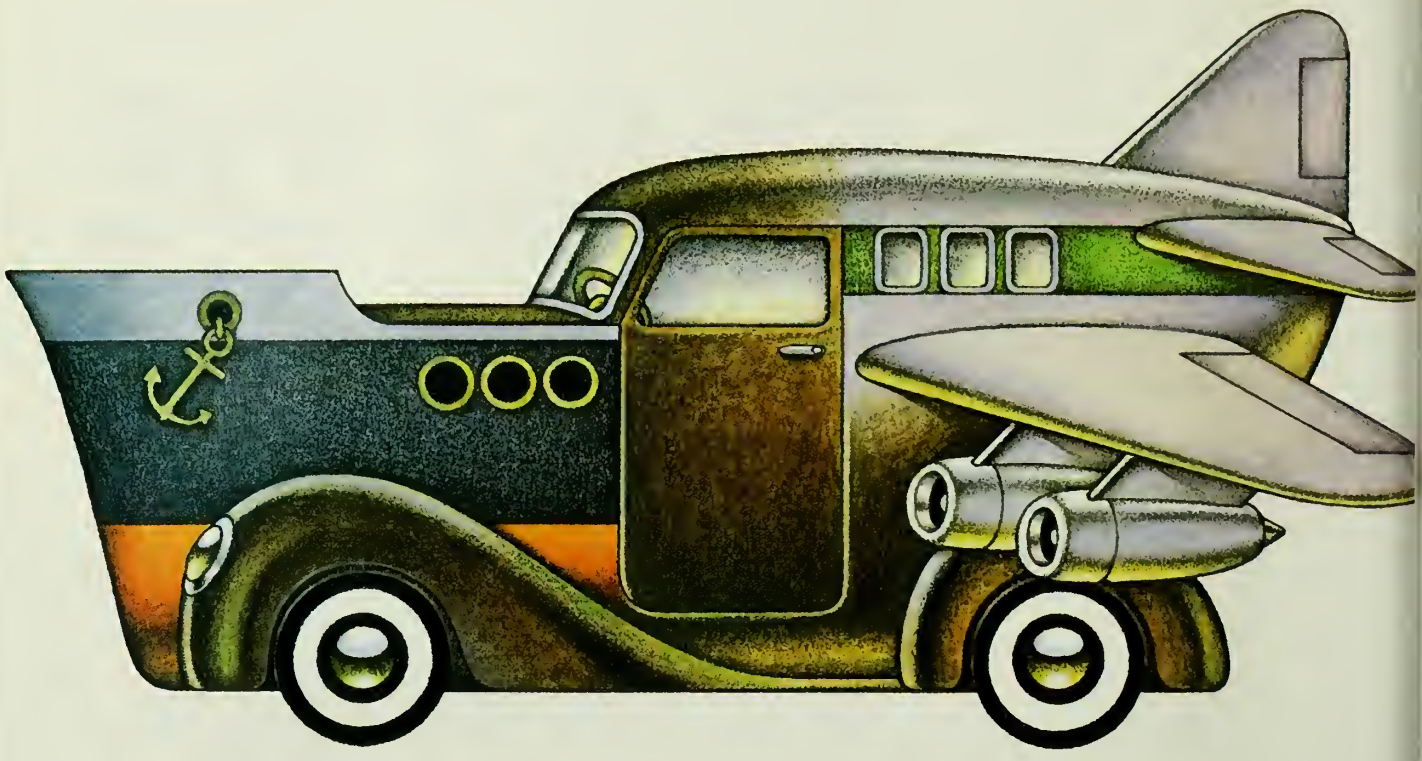
Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F CO.
Carolina, P.R. 00630
Subsidiary of
SmithKline Corporation

TO KEEP BLOOD PRESSURE DOWN AND KEEP POTASSIUM LEVELS UP



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Up to 24 hours of effective control with a single dose...in nausea, vomiting and dizziness associated with motion sickness.

Dosage: 25 to 50 mg. 1 hour before travel.

Available on prescription only.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25 Chewable Tablets
(meclizine HCl) 25 mg.

for motion sickness

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MDs in the news

THE STATE SOCIETY offers a day of orientation at PMS Headquarters for all newly installed county society secretaries. In the photograph on the left are Stanley Mayers, Jr., M.D., of the Centre County Medical Society (Right) and Ronald M. Bachman, Society Director of Economic Affairs. On the right is Philip C. Grana, M.D., Bedford County Medical Society, (Right) with John Rogalski, assistant secretary for the State Society.

The Lehigh County Medical Society honored three doctors recently at its annual inaugural dinner. **Fred M. Haas, M.D.**, received a citation from the State Society for 50 years of medical service. Recognized for outstanding efforts and devotion during 1974 were **David A. Tilly, M.D.**, and **Michael H. Ufberg, M.D.**

Whittier C. Atkinson, M.D., founder of Atkinson Memorial Hospital in Coatesville, was honored recently by PMS for 50 years of service as a physician. In 1932, Dr. Atkinson started a five bed hospital next to his home. After expansion five years later it became Clement Atkinson Memorial Hospital, named for Dr. Atkinson's father.

Two Berks County physicians, **Herman F. Kotzen, M.D.**, and **Martin M. Wassersweig, M.D.**, were honored recently by the State Society for 50 years of medical service.

William Weiss, M.D., F.A.C.P., was recently appointed director of Hahnemann Medical College and Hospital's new division of occupational health in the department of medicine. Dr. Weiss had received the Merit-In-Authorship Award of the American Occupational Medical Association for his work as a member of the editorial board of the *Archives of Environmental Health.*

George Manstein, M.D., chairman of the department of plastic surgery at Albert Einstein Medical Center, Northern Division, attended the recent annual meeting of the American Society of Plastic and Reconstructive Surgery in Houston, Texas. As the outgoing president of the Robert H. Ivy Society of Plastic Surgery, he delivered a eulogy on the recent death of Dr. Ivy, who had been a professor of plastic surgery at the University of Pennsylvania and editor of the *Plastic and Reconstructive Surgery Journal.*

Willard Arthur Krehl, M.D., one of the country's leading nutritionists, has been appointed medical consultant to the Vitamin Information Bureau. Dr. Krehl is professor and chairman of the department of community health and preventive medicine at Jefferson Medical College. He is past president of the American Board of Nutrition and American Society of Clinical Nutrition and a member of the board of directors of the American Heart Association.

Madhav V. Phadke, M.D., Oil City, was recently named a diplomate of the American Board of Surgery.

Samuel B. Hadden, M.D., of Wynnewood, recently delivered the biennial Slavson Address, "A Glimpse of Pioneers in Group Psychotherapy," at the annual meeting of the American Group Psychotherapy Association. After the meeting Dr. Hadden presented a paper on group psychotherapy before the Mexican Psychiatric Society. Dr. Hadden is one of the pioneers of group psychotherapy and began the use of a group approach to emotional problems in 1937. He is president of the International Association of Group Psychotherapy.

Anthony Francis Cole, M.D., was recently appointed assistant professor of family and community medicine in the Pennsylvania State University College of Medicine at the Milton S. Hershey Medical Center. Dr. Cole was formerly acting director of the family practice residency program and visiting professor of family medicine at the University of North Carolina.

Albert N. Brest, M.D., Wyncote, has been named the first James C. Wilson Professor of Medicine at Jefferson Medical College. The newly endowed professorship was established by the late Beatrice A. Wilson, daughter of the distinguished Philadelphia doctor who was head of the department of medicine at Jefferson from 1891 to 1911. Dr. Brest is also director of Jefferson's division of cardiology.

Charles B. Beymer, M.D., director of student health services at Indiana University of Pennsylvania, recently received a plaque from the State Society in recognition of his 50 years in the practice of medicine.

Manoochehr Yashari, M.D., Pottstown, was recently named a diplomate of the American Board of Obstetrics and Gynecology. Dr. Yashari is an obstetrician, endocrinologist, and a specialist in infertility.

Leroy A. Rodgers, M.D., was named a diplomate of the American Board of Family Practice recently. He is director of the division of ambulatory care and community medicine at Memorial Hospital, Johnstown, and a member of the American Academy of Family Physicians.

John Caffey, M.D., has been selected to receive the Gold Medal from the American College of Radiology at its 52nd annual meeting. Dr. Caffey is on the staff of the radiology department of Children's Hospital of Pittsburgh. Since 1927 only 61 Gold Medals have been awarded by the college.

Julius Mazer, M.D., director of radiology at the Magee Womens Hospital, Pittsburgh, has been promoted to professor of clinical radiology at the University of Pittsburgh School of Medicine. Dr. Mazer is also the radiological director of the department of ultrasound at Magee Womens Hospital.

John Hume, M.D., recently became director of Norristown State Hospital. He replaced Frank Kaplan, M.D., who was acting director. Dr. Hume is secretary to the Central Pennsylvania Psychiatric Society and a member of the American Association for Mental Deficiency.

Wylie L. Overly, M.D., Latrobe, was recently certified in the subspecialty of hematology by the American Board of Internal Medicine. Dr. Overly is also certified in the subspecialty of oncology and the broad specialty of internal medicine. He is a fellow of the American College of Physicians and a member of the American Society of Hematology.

John B. Houston, M.D., was recently named director of the department of anesthesiology at the Geisinger Medical Center, Danville. He is certified by the American Board of Anesthesiology and is a member of the American, Pennsylvania, and Philadelphia Societies of Anesthesiology.

Subrata Barua, M.D., was recently elected a fellow of the American College of Surgeons. He is a diplomate of the American Board of Orthopedic Surgeons and a member of the Tri State Orthopedic Society.

Donald W. Spigner, M.D., recently became medical director of Hamilton Health Center in Harrisburg. He was formerly the director of the Pilot City Comprehensive Neighborhood Health Center in Mineapolis, Minnesota.

George E. Ehrlich, M.D., has recently returned from a trip which he took to Japan at the invitation of Professor G. Shimiusu, chairman of the Committee on Behcet's Disease and professor of medicine at Tokyo University Medical School.

Mary Romeika, M.D., Shenandoah, was recently named a charter fellow of the American Academy of Family Physicians. Dr. Romeika had previously received the PMS Voice of Medicine citation.

F. Owen Black, M.D., was recently appointed head of the new division of vestibular diseases within the department of otolaryngology of Eye and Ear Hospital of Pittsburgh. At the same time, Dr. Black was appointed associate professor of otolaryngology in the University of Pittsburgh School of Medicine.

George L. Jackson, M.D., director of nuclear medicine at Harrisburg Hospital, was appointed recently to the Advisory Committee on Nuclear Medicine to the Joint Commission on the Accreditation of Hospitals. Dr. Jackson is certified by the American Board of Internal Medicine and American Board of Nuclear Medicine. He is also on the American College of Nuclear Physicians' Board of Regents and is chairman of the steering committee for the Pennsylvania Chapter of the American College of Nuclear Medicine.

continuing education

This issue carries no education course listings. The January issue contained a supplement—a comprehensive list of education courses being offered in all parts of Pennsylvania. Consult that issue or write for a copy of the supplement to: Pennsylvania Medical Continuing Education Institute, 20 Erford Rd., Lemoyne, PA 17043.

MDs in the news

Your man in Lemoyne

Ralph K. Shields, M.D. - Third District

ROBERT WEISER
Communications Division

Dr. Ralph K. Shields, trustee of the Third Councilor District decided on a career in medicine more than 44 years ago.

"I found it a very exciting and challenging profession with what appeared to be unlimited opportunity to help people while earning a good living," said Dr. Shields reflecting on that decision.

After completing his premedical education at the Pennsylvania State University, he attended the Duke University School of Medicine and received his degree in 1935. He served his internship and residency at Henry Ford Hospital in Detroit from 1935 to 1938. He is a member of the Alpha Omega Alpha honor medical fraternity.

A native of Bethlehem, he returned there to practice internal medicine in 1939. This was interrupted by four years of service in the Army Air Force from 1942 to 1946.

Today Dr. Shields still practices in Bethlehem. But for the last five years he's had a partner—one of whom he's particularly proud—his son, Dr. Ralph L. Shields.

Dr. Shields, a member of the Executive Committee of the Board, attends a joint meeting with the Executive Committee of Pennsylvania Blue Shield.

Dr. Shields is on the staff of St. Luke's Hospital. He is certified by the American Board of Internal Medicine and served as chief of the hospital's department of medicine from 1955 to 1968, a position he still holds in emeritus. He also served as a medical trustee of St. Luke's from 1967 to 1970.

The Bethlehem internist first joined organized medicine 36 years ago. "It was pretty much expected of all physicians who wanted hospital privileges. While that was part of my reason for joining, I also wanted the opportunity to obtain the help and guidance of the leaders of the medical community. I felt a physician should belong to an organization that met together for educational purposes," he explained.

A trustee of the State Society since 1968, Dr. Shields has also served as a member of the House of Delegates, as vice chairman of the former Council on Scientific Advancement, and as chairman of the Officers' Conference Committee for two years. He is a past president of the Northampton County Medical Society and a fellow of the American College of Physicians.

While serving as a leader in his profession he also serves as a leader in his community. He is an elder of the Central Moravian Church in Bethlehem, and a member of the Provincial Elders Conference of the Moravian Church, the governing body of that denomination in the western and northern United States and Canada. He is a director of the Chamber of Commerce, a past president of the Rotary Club, a former member of the board of the Community Chest, chairman of the Board of Trustees of Moravian Academy, and a member of the Board of Directors of the Eastern Pennsylvania Heart Association.

With all of these interests, why the continued involvement in organized medicine?

To Dr. Shields organized medicine has a definite role to play in the future of medicine.

"It's my feeling that organized medicine should and does provide a mechanism for meeting problems with a united front," said Dr. Shields pointing out that this includes dealing with third parties and the government at all levels as well as keeping an emphasis on educational needs of physicians.

Membership in organized medicine is an extension of the desire to help people that first drew him into the profession.

"All of the goals of organized medicine really translate and end ultimately with a benefit to patient care. That's what it all boils down to," he emphasized.

George A. Rowland, M.D. - Fourth District

DEBORAH L. RUSSELL
Editorial Assistant

From the time he first decided to become a physician, George A. Rowland, M.D., has been primarily interested in family medicine. The satisfaction of working with and for people has provided motivation for his work. Dr. Rowland received his medical degree from Temple University Medical School in 1942. After a residency in pediatrics at St. Christopher's Hospital for Children in Philadelphia, he entered the United States Army Air Corps as a captain in the medical corps. Upon leaving the army, Dr. Rowland joined the medical staff of Bloomsburg Hospital where he is an active staff

Dr. Rowland, center, at AMA Delegation Hearing at 1974 Annual Meeting.

member, having held most offices including chief of staff.

Consistent with his philosophy of the private practice of medicine is Dr. Rowland's conception of organized medicine. "Providing a mechanism for the medical profession, as opposed to the individual physician, to relate to the rest of society," is the main purpose of a medical organization. "I don't think it is meant to combat anything," he replied, when asked about fighting social evils. But in his opinion, to try to remedy some of the medically related problems is certainly one of the functions of an organization such as the Pennsylvania Medical Society.

Dr. Rowland began activity in organized medicine when he joined the Columbia County Medical Society in 1947. Various elective offices which he has held in that organization include vice president in 1950, two terms as secretary 1951-53 and 1956-59, and president in 1955.

Dr. Rowland was a member of the State Society's House of Delegates from 1951 until 1966 when he was elected to the Board of Trustees and Councilors for completion of the unexpired term of the late Joseph J. Leskin, M.D., of the Fourth District. He has served the Society in various capacities including vice chairman of the Board, chairman of the Finance Committee, member of the Executive Committee, and chairman of the Commission on Rural Health and the Officers' Conference Committee.

For Dr. Rowland, keeping physicians informed and educating the public are important functions of organized medicine. From 1963 to 1972 he was editor of the Columbia County Medical Society bulletin and spent several years as a member of the Publication Committee for the State Society. A talented writer, Dr. Rowland has written frequently for PENNSYLVANIA MEDICINE on subjects such as the use of hexachlorophene on newborn infants (March 1972), and a lesson on what happens when an organization becomes too strict and narrow in its purposes (July 1974).

When asked about opinions not yet on paper, Dr. Rowland mentioned an idea suggested by criticism of operations performed by unqualified surgeons. "It seems strange that so much family medicine is being done by people who are not trained appropriately for it. Many specialists with training designed to make them consultants are trying to practice primary and family medicine. . . ."

Another of Dr. Rowland's concerns is the difficulty in keeping doctors in rural locations. "They make themselves too available at first and the practice soon engulfs them." The solution is "benevolent selfishness," by which a physician places his own family and life ahead of his practice. Having time for himself and his family, he will be more likely to remain in the community.

In addition to Dr. Rowland's work in the County and State Societies, he is a delegate to the American Medical Association and active in the Section of Family and General Medicine. He is a diplomate of the American Board of Family Practice and past president of the Pennsylvania Academy of Family Physicians. Active as a member of the American Academy of Family Physicians, he is currently vice president and chairman of the Commission on Education. He has also worked on the county and state level for the American Cancer Society.

Dr. Rowland's accomplishments in organized medicine illustrate the sense of purpose and concern for humanity that have accompanied him throughout his medical career.

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Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

WRITE FOR LITERATURE AND SAMPLES

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REFER TO PDR

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androgenic deficiency

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Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

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Must vasodilators and therapy for other diseases come into conflict?

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The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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practice management

Three ideas to improve your office procedure

LEIF C. BECK, LI. B.
VASILIOS J. KALOGREDIS, J. D.
Bala Cynwyd

These simple systems—budget, reminder box, and insurance form suspense file—can improve the functioning of your entire office and require minimal effort to implement.

In our surveys of medical practices, we often come upon small ideas which seem so obvious yet have been totally unknown to the clients. Three common examples are the adoption of a regular, periodic practice budget system, reminder box system, and insurance form suspense file system. These systems can be most helpful, and proper implementation of them can improve the management efficiency of any medical practice.

Practice budget

The difficulty with the word "budget" in many doctors' minds are its connotations—strict control, rigidity, and even worse, a feeling of admission of failure to reasonably and prudently constrain spending habits without the help of a budget if it is determined that one should be instituted.

Purpose—However, *the primary purposes of a budget are to aid the practice's physicians in identifying practice goals with respect to income generation, in identifying the amount of effort required to achieve such goals, and in determining one's progress towards such objectives by periodic comparison of "real" and "budget" figures.*

Therefore, although a budget does require a certain amount of adherence to a predetermined pattern of spending, that is not its prime purpose. Its primary contribution is as an aid in setting objectives and in establishing a fiscal plan which will achieve them.

No professional practice should be considered too small for the budget approach to financial planning. It has proven beneficial even to sole practitioners. There is no denying that fiscal complexities increase with the size of a group and the need for a budget increases proportionately. Still, the matter of size of the group should only relate to the degree of refinement of the budget, not to whether there should be one at all. No matter how small the practice, some form of budgetary guidelines should be instituted, even if rudimentary.

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd, Pennsylvania.

How a budget is established—The Practice Budget Format demonstrates the *planning* application of a budget. It deals with an internal medicine group composed of three internists, practicing as a professional corporation, on a calendar year basis, with part of their income from teaching and hospital activities and part from in-office laboratory, X-ray and EKG services.

This budget was developed in the following manner:

Under column 1 the actual experiences of the practice for 1974 (the preceding taxable year) were listed, broken down into the major categories of services rendered, receipts, operating expenses and capital expenses (asset purchases). It is important that the service components be identified in as much detail as possible since they are critical parts of the budget both from the planning side ("before") and from the evaluation side ("after"). In this illustration, we have broken them down into five components.

Under column 2, *starting with the expenses* (category C), an estimate of the probable experience for the twelve months of 1975 was made. The expenses of elective magnitude (professional salaries and profit sharing plan) were ignored at first. In determining cost probability of the nonelective expenses, elements of inflation and increased volume had to be considered. In making such budgetary projections a physician should

check his office lease for possible rental adjustments, consider salary adjustments (and accompanying payroll taxes) or additional personnel needs, check his retirement plans to see if additional employees will have to be covered, anticipate malpractice insurance increases and the like. Going through this procedure is valuable in itself, for it increases the physician's familiarity with the areas of highest cost stress in his practice's operations.

The direct salary objectives of the physicians were then considered. The salary must be realistic and coordinated with the elective profit sharing plan contribution. In our example, the doctors had salaries of $54,000 each in 1974, and set a goal of $60,000 each for 1975.

Capital expenditures likely to be required were then projected and were entered in Category D.

All of the expenses and capital expenses were then totalled. The gross receipts necessary to pay the expenses and capital expenses while leaving enough cash to satisfy corporate requirements for dividends and taxable income was determined. That figure was placed opposite "TOTALS" in category B. The amount of income expected from institutional sources was then entered (usually relatively easy to project). The difference between projected total receipts and institutional work must, of course, come from patients.

The gross projected receipts were then multiplied by 107 percent (but this can vary depending on your collection experience). This then provided us with the gross services rendered needed to produce the projected gross receipts, allowing for collection losses.

The gross services required among the doctors and other income producing activities (in category A) were then determined, based upon previous experience and realistically achievable modifications of practice volume, fees, and the like.

Column 3 contains the monthly average of all entries (determined by dividing all the entries in column 2 by 12).

Columns 4 and 5 were calculated monthly during the year. Column 4 being the average monthly budget figure multiplied by the months of the fiscal year which have elapsed. Column 5 is the actual experience for the year to date.

We strongly recommend that a monthly financial statement also be prepared. This will allow the physician to more easily determine where the high and low expense, production and collection points for a specific month are. While they might be incorporated into an additional column on the budget, space may require the one-month information to be on a separate sheet.

By using such a budget, a practice can set its financial objectives and keep a continuing eye on the progress being made towards achieving those goals. Care should be taken, however, in the monthly comparisons of columns 4 and 5 since income and expense items do not follow convenient patterns. However, the patterns should be quantifiable. For example, the Business Taxes expense in column 5 ($3,400) is much higher than the column 4 figure (2,000). At first glance this may cause panic. However, upon reflection the reason for this disparity is explainable—the three high salaried physicians are subject to Social Security taxes for the first few months of the year, therefore causing a proportionately high tax figure budgetwise for that quarter. The payroll taxes will be proportionately less for the rest of 1975 and therefore appear to be back on course with the budgetary projections.

Each item in the budget should be explored in that manner to determine the reason for any disparity. The real advantage of this system is that immediate warnings of any potential difficulties are sounded, so that action can be taken. For the practice which only gets a semi-annual or even annual report which can only report what has happened, it is usually too late to do anything about it when the information becomes available.

Reminder box

This is a handy little device that is simple to use and costs little. It is not used as much as it should be by most medical practices.

The simplest (and most used) is a 3″ x 5″ file card box with dividers for the days of the present month and the month thereafter, and then for all other months and succeeding years. The uses to which this box can be put are endless.

The most common use is as the bulwark of the "recall system" we recommend for a sound collection system. For example, when a patient is first contacted as to an overdue account, his name and information can be placed on a card and filed for followup on the appropriate day. Any further contact with the patient can be recorded on the file card, thus providing a record of the responses. Practices which have instituted such a system with our assistance have been most pleased with the results. It makes the aide's job easier since there may only be a few cards coming up on a given day, making it a little more bearable for her to deal with, and keeping her from falling too far behind.

The "reminder box" can also be put to good use when dealing with patient recalls. For example, an internal medicine practice we recently surveyed never scheduled patients more than three months in advance. This had caused problems since there was a large volume of annual physical examinations. They were giving each patient a card stating the approximate date for next year's physical, making no record of it on the practice's records and leaving it totally up to the patient to remember his next visit. We suggested a new policy simply using the "reminder box" and some cards. Now, whenever a "recall" patient comes to the reception desk to check out, the receptionist provides a 3″ x 5″ card to fill out (name, address, phone number, doctor, approximate date of next visit). The receptionist then places the card in the file box at the appropriate date and when it turns up the patient can be contacted to set up an appointment. It has worked wonderfully. The only

difference is placing the card in the file box instead of giving it to the patient.

Other examples of uses for the box are for remembering hospital meetings, prescriptions, or anything else requiring reminders.

For such a simple and inexpensive item, the "reminder box" can help a physician avoid embarrassment and give him the appearance of the highest of efficiency and organization.

Insurance form suspense file

A practice we recently surveyed was keeping a log book for open third party insurance claims. As the volume of the practice grew, the book became much too cumbersome. It was very difficult to find any single claim form, and the mass of names discouraged an aide from tackling any followup job at all.

We recommended that a third party insurance "suspense file" be established in which all insurance form copies would be filed in chronological order (rather than alphabetical order). By so setting it up, the insurance clerk (or any person, for that matter) could at any time check and review the oldest outstanding insurance claims. There would be no real difficulty if a patient or other person should call about an insurance situation, since the aide would in any case first pull the patient's ledger card showing the date the insurance claim was filed. She could then go to the chronological "suspense file" to determine whether the insurance claim is still outstanding, whether it should be followed up to the insurance company, etc.

This has proven to be very useful to many practices and is another suggestion for improving practice management.

PRACTICE BUDGET FORMAT*
(Example)

	(1)	(2)	(3)	FOUR MONTHS (4)	FOUR MONTHS (5)
	1974	1975	Monthly	Year To Date	Year To Date
A. Services Rendered	(Actual)	Budget	Average	(Budget)	(Actual)
Institutional	$ 37,000	$ 42,000	$3,500	$ 14,000	$ 14,200
Dr. A	91,000	96,000	8,000	32,000	33,000
Dr. B	83,000	90,000	7,500	30,000	28,600
Dr. C	69,000	84,000	7,000	28,000	26,400
Lab, X-Ray and EKG	52,000	60,000	5,000	20,000	19,300
TOTALS	332,000	372,000	31,000	124,000	121,500
B. Receipts					
Patients	275,000	306,000	25,500	102,000	99,000
Institutional	37,000	42,000	3,500	14,000	14,000
TOTALS	312,000	348,000	29,000	116,000	113,000
C. Expenses					
Drugs & Medical Supplies	9,300	10,800	900	3,600	3,300
Utilities	1,600	1,800	150	600	700
Telephone	1,900	2,100	175	700	800
Professional Salaries	162,000	180,000	15,000	60,000	60,000
Non-professional Salaries	42,000	48,000	4,000	16,000	16,800
Office Expenses	5,200	5,400	450	1,800	2,100
Postage	900	1,200	100	400	500
Billing Expense	5,600	6,000	500	2,000	2,300
Dues & Subscriptions	1,300	1,500	125	500	400
Business Taxes	5,200	6,000	500	2,000	3,400
Business Insurance	2,200	2,700	225	900	400
Rent	14,400	14,400	1,200	4,800	4,800
Repairs & Maintenance	700	900	75	300	600
Laboratory Expense	5,500	6,000	500	2,000	2,400
Automobile Expense	3,400	3,900	325	1,300	1,400
Meetings & Conventions	2,100	2,400	200	800	300
Professional Expense	1,800	1,800	150	600	400
Profit-Sharing Plan	27,000	30,000	2,500	10,000	7,500
Pension Plan	8,300	9,600	800	3,200	2,400
Employee Benefits	7,100	7,500	625	2,500	1,200
TOTALS	307,500	342,000	28,500	114,000	111,700
D. Capital Expenses	1,400	1,200	100	400	—
BALANCE	3,100	4,800	400	1,600	1,300

** This example has been prepared by Thomas E. Zirkle, CPBC, of Larkspur, Colorado, for presentation to the PMS Practice Management Seminar. The authors express their appreciation for its use.*

HEW recommends on use of BCG vaccine

During 1974 there were 30,000 new cases of tuberculosis and 3,600 tuberculosis deaths, reported *Morbidity and Mortality Weekly Report* (Vol. 24, No. 8), a publication of the U.S. Department of Health, Education, and Welfare's Center for Disease Control. The rates per 100,000 population were approximately 14.3 new cases and 1.8 deaths, 46 percent and 58 percent lower than in 1964.

Early identification and treatment and preventive therapy have been effective in controlling the spread of tuberculosis. The Bacillus of Calmette and Guérin, the BCG vaccine, has been used in preventive therapy for those at high risk who are unavoidably exposed to tuberculosis.

Although other methods of preventive treatment are successful, the BCG vaccine may be quite useful in certain cases, for example, uninfected persons repeatedly exposed to infective persons not undergoing treatment at the time.

Morbidity and Mortality (p. 70) names some specific recommendations for use of the BCG vaccine:

> 1. BCG vaccination should be seriously considered for persons who are tuberculin skin-test negative and who have repeated exposure to persistently untreated or ineffectively-treated sputum-positive pulmonary tuberculosis.
>
> 2. BCG vaccination should be considered for well-defined communities or groups if an excessive rate of new infections can be demonstrated and the usual surveillance and treatment programs have failed or have been shown not to be applicable. Such groups might exist among the socially disaffiliated and those without regular source of health care, possibly including some alcoholics, drug addicts, and migrants. . . .

The BCG vaccine should be used for patients who are skin test negative to 5 toxic units of tuberculin, purified protein derivative. A repeat tuberculin skin test should be given two to three months after the vaccine. Vaccination should be repeated if that skin test is negative and indications for BCG remain.

Dosage and route of vaccination should be according to the package labeling. Newborn infants should receive only half the usual dose; revaccination with the full dose can be performed when the child is one year of age if indications for BCG remain.

Physicians should avoid giving BCG to persons with impaired immune response. Examples are those with leukemia, lymphoma, generalized malignancy, or whose response has been suppressed by steroids, alkylating agents, radiation, or antimetabolites. Pregnant women should not receive the vaccine unless exposure to infective tuberculosis is unavoidable.

Because it is difficult to distinguish between a tuberculin reaction caused by superinfection and one caused by sensitivity after the vaccination, physicians must be cautious when attributing a positive skin test to the vaccine. This is especially the case if the vaccinee has been recently exposed to infective tuberculosis.

There is no guarantee that the BCG vaccine will provide complete and long lasting protection from tuberculosis. Differential diagnosis of a tuberculosis-like disease in a BCG vaccinee should include tuberculosis.

List transplant hospitals

The Delaware Valley Transplant Program, a non-profit cooperative cadaver kidney procurement effort, involves staff members from six Philadelphia area hospitals: Thomas Jefferson University Hospital, Albert Einstein Medical Center, Hahnemann Hospital, Lankenau Hospital, St. Christopher's Hospital, and the Hospital of the University of Pennsylvania. Due to an oversight, the name of Thomas Jefferson University Hospital was omitted from the article appearing in the February 1975 issue.

Child abuse report ready

The National Institute of Mental Health has recently published *National Conference on Child Abuse: A Summary Report.* The report summarizes a two-day conference in Washington, D. C., attended by authorities on child abuse from national, state, and private agencies throughout the country. Participants represented medicine, law, mental health, and education.

The report includes discussion of specific issues and recommendations made in the conference's five workshops, which deal with identification of child abuse, legislation, prevention and rehabilitation, education, and research.

Copies of the report can be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402 at a cost of $.75 each. When ordering, refer to stock number 1724-00390 and DHEW Publication Number (ADM) 74-117.

'Credit card' education plan in effect at Hershey

In order to serve more efficiently the continuing education needs of physicians, the Milton S. Hershey Medical Center's department of continuing medical education is implementing a computerized physician registration system. The new program is designed to reduce the clerical labor previously required to register physicians, keep transcripts of earned credits up to date, and inform physicians of accumulated credits, programs, and conferences to be held at the medical center. The program will meet the needs of the busy practitioner by maintaining accuracy of records and automatically informing him of programs attuned to his specialty or interest.

Each physician in the central Pennsylvania area is issued a plastic card embossed with his name and a computer coded number. On the back of the card is a schedule of weekly education programs at the Hershey Medical Center.

A physician participating in a program registers his attendance with the plastic card and a special "Registration and Answer Form." The form is a standard size IBM card and contains space for the doctor's name and number, program date, and amount of credit offered. True-false and multiple choice answer spaces also appear on the card since American Medical Association Category I credit programs must include an evaluative measure of educational objectives.

The plastic card and registration and answer form, along with program information, are fed into a data imprinting machine, similar to those used for credit charges. All relevant information is then printed onto the form which is given to the physician.

Correlating with the form is an auxiliary information sheet supplied by the sponsor of the program. The sheet contains pertinent information such as names of speakers, case histories, references and bibliography, educational objectives and evaluation necessary for credit acquisition.

At the conclusion of the program, the physician leaves his form at the registration desk and keeps the auxiliary information sheet for his own reference.

Registration and answer forms are sent to the computer service of Hershey Medical Center. Information from them is keypunched into the computer which stores it in memory discs. Through weekly mailings, a physician learns the amount of credit he earned during the previous week. He also receives an annual notice regarding accumulated credit.

The physician receives, also on a weekly basis, a computerized data mailer which tells about programs in which he may be interested. The variable of interest is determined in two ways. In the first, department heads review the content of programs and determine which programs would benefit various specialties. In the second, the physician indicates his specialty and interests. The computer is then programmed to send out information relevant to each physician.

To announce the initiation of this system, each central Pennsylvania physician will receive an information packet containing an explanatory letter from Harry Prystowsky, M.D., dean of the college of medicine, outlining the mechanics and purposes of the system. Also in the packet will be an individualized plastic card, a sample registration and answer form and data mailer, and a listing of all regularly held continuing medical education programs.

ABFP schedules test

The American Board of Family Practice will give its next two day written certification examination on November 1-2, 1975. It will be held at five centers geographically distributed throughout the United States.

Physicians who wish to take the examination must first submit a completed application to the board office. The absolute deadline for filing applications is June 15, 1975.

For more information regarding the examination, write: Nicholas J. Pisacano, M. D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, KY 40506.

X-ray guide available

A reference booklet, "A Practitioner's Guide to the Diagnostic X-ray Equipment Standard," is now available from the Food and Drug Administration's Bureau of Radiological Health. The ten-page pamphlet highlights major provisions of the standard and summarizes what practitioners need to know to meet their responsibilities.

Single free copies are available from the Bureau of Radiological Health (HFX-25), 5600 Fishers Lane, Rockville, Maryland 20852. Multiple copies may be purchased at $.40 per copy from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. Orders of 100 or more receive a 25 percent discount. Stock number 1715-00075 should be used in ordering from G. P. O.

JCAH accreditation now includes consumer interview

In 1973, the Joint Commission opened the door for consumer input during hospital accreditation surveys. This summer it moved to put teeth in this policy. Survey instructions now state:

"Every facility scheduled for a JCAH accreditation survey must now post notice in a public place announcing the date of the survey and stating that there is an opportunity for a public information interview. Such public notice must be posted at least four weeks prior to the survey date . . . Anyone requesting an interview must give notice at least two weeks prior to the survey to allow the facility sufficient time to make suitable arrangements and to enable the surveyor(s) to arrange their schedule accordingly. The facility must refer any such requests to the Joint Commission; this policy is effective immediately for all facilities seeking accreditation."

Instructions say that "publication in the mass media" is not necessary. The request for a consumer interview must be in writing and must be received by the joint commission at least two weeks prior to the survey. The hospital must forward the requests to the joint commission. Information obtained in a survey, including the interview, are confidential matters between the commission and the health facility.

Some doctors believe that substandard performers should not receive medical staff appointments. Joint Commission Director John Porterfield, M. D., said this is not so. "Medical staff members more readily admit patients to the hospital at the proper stage of illness than do non-members who must relinquish the care of their patients upon hospital admission," he said. The commission calls for citizenship status for all physicians within the hospital medical staff, and for careful monitoring and supervision of the privileges given by the credentials committee.

Nothing has caused more controversy than the Commission's attempt to evaluate the delineation of medical staff privileges. One of the misadventures here was development of the so-called "laundry lists" of things that a doctor could or could not do. JCAH staff said that these long lists of privileges are not required from hospitals surveyed.

"At present," Dr. Porterfield said, "the JCAH does not require or recommend any specific form for delineation of privileges." Some of the methods to define clinical privileges included disease entities, defined surgical and medical procedures, anatomic systems, organs, areas of competence specified by subspecialty boards, or a combination of these and others. JCAH stated: "The precise method for delineation of privileges is left by the joint commission to individual medical staff discretion with the proviso that in any case it must be done."

Regardless, initial privileges should be related in part to previous clinical experience and reports on that experience. Under Pennsylvania's new peer review immunity law the credentialling process is specifically covered. The definition of "review organization" in Public Law 193 includes "any hospital board or committee reviewing the professional qualifications or activities of its medical staff or applicant for admission thereto." The way should be open now for medical staffs in the Commonwealth to vigorously investigate new applicants to hospital medical staffs.

Dr. Porterfield has said: "Staff membership as well as the privileges granted must be temporal—usually for not less than one nor more than two years. Most of the ambiguities inherent in the evaluation procedure should not exist during the reappraisal process, as the evaluation can now be based on actual hospital performance."

Never directly addressed, but always present, is the question of the aging physician. The requirements of the joint commission and the protection afforded by the peer review immunity law in Pennsylvania would seem to lay the responsibility squarely on hospital medical staffs to curtail the activities of aging and ill physicians.

Allergists to meet

The Pennsylvania Allergy Association will hold its twenty-seventh annual spring meeting June 13-15 at Hotel Hershey, Hershey. Major topics to be discussed are asthma, the patient with increased susceptability to infection, and allergy and the skin. Among the scheduled speakers are: Nicholas M. Nelson, M. D., professor and chairman of the department of pediatrics at Milton S. Hershey Medical Center; David Gitlin, M. D., professor of pediatrics at the University of Pittsburgh School of Medicine; Rebecca H. Buckley, M. D., chief, division of allergy, immunology and pulmonary diseases in the department of pediatrics at Duke University Medical Center; and Paul S. Porter, M. D., director of the department of dermatology at the University of Pittsburgh School of Medicine.

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Because iodine content rather than biological assay is used to measure the standard of many desiccated thyroid products, biologic activity can vary from batch to batch. Even when biologic assay is employed, biologic activity can only be approximated.

1 It is recognized that T_4 and T_3 content in desiccated thyroid and thyroglobulin varies from animal to animal, by animal species, geography, and animal diet.

2 Of therapeutic concern: In addition to varying amounts of T_4, desiccated thyroid may contain varying amounts of T_3, a potent compound with rapid onset and fleeting action that can produce metabolic surges.

3 Even when kept under proper storage conditions, desiccated thyroid deteriorates more rapidly than the synthetic hormone.

4 The "usual maintenance dose" for the widely prescribed desiccated thyroid is "from 1 grain to 3 grains per day, but it may vary, in individual patients from 1/2 grain to 10 grains."[1] The "usual maintenance dose" of the most widely prescribed thyroglobulin (which is also a desiccated thyroid product) is "0.5 to 3.0 grains daily."[2]

1. Armour Thyroid (Tablets). 1975 Physicians' Desk Reference. p. 561.
2. Proloid® (thyroglobulin). 1975 Physicians' Desk Reference. p. 1575.

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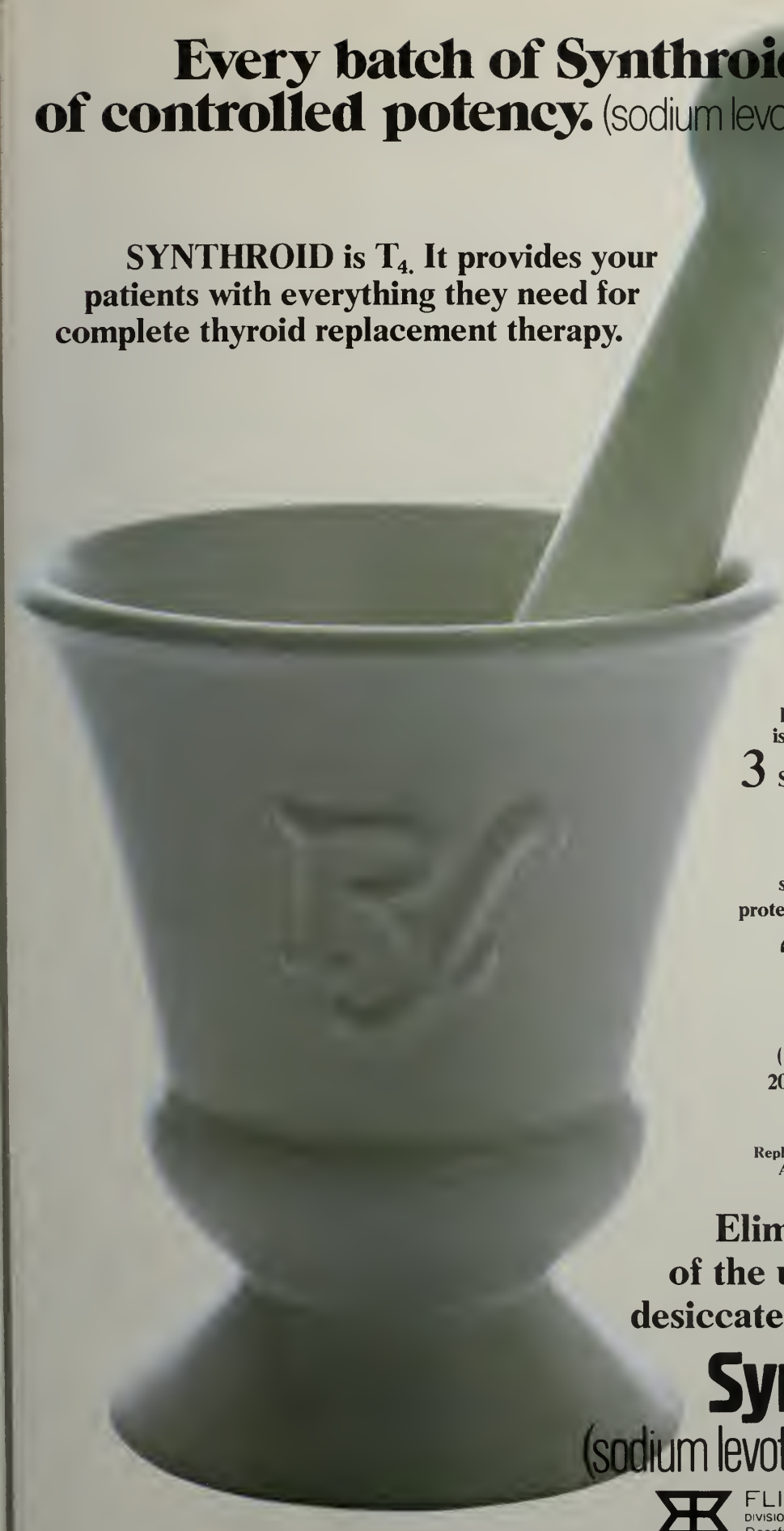

SYNTHROID is T_4. It provides your patients with everything they need for complete thyroid replacement therapy.

1 Sodium levothyroxine is *not derived* from any animal gland source. It is a synthetic and, since sodium levothyroxine is the only active ingredient, its weight is the sole determinate of potency.

2 SYNTHROID (sodium levothyroxine) is T_4 which is converted by the patient to T_3 at the cellular level, thereby providing a physiologic source and amount of T_3 to meet metabolic needs for complete thyroid replacement therapy. Because the onset of effect is slower and more steady, the possibility of sudden metabolic surges is reduced with SYNTHROID therapy.

3 SYNTHROID (sodium levothyroxine) products have a longer and more reliable shelf life than Thyroid U.S.P. when kept under the same proper storage conditions. There is no animal protein present in SYNTHROID products.

4 A recent study of 44 patients with hypothyroidism indicates that 89 percent of the patients were maintained with doses of L-thyroxine (SYNTHROID) between 100 mcg. and 200 mcg. (0.1 mg. and 0.2 mg.) per day.[3]

3. Stock, J.M., Surks, M.I., and Oppenheimer, J.H.: Replacement dosage of L-thyroxine in hypothyroidism. A re-evaluation. New Engl. J. Med. *290*:529-33, 1974.

Eliminates many of the uncertainties of desiccated thyroid therapy.

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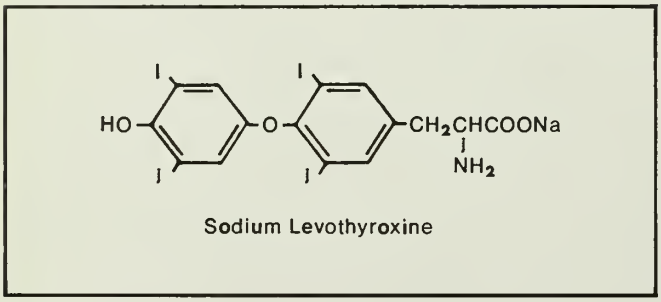
Synthroid Tablets—for oral administration
Synthroid for Injection—for parenteral administration

Description

SYNTHROID (sodium levothyroxine) **Tablets** and SYNTHROID **Injection** contain synthetic crystalline sodium levothyroxine (L-thyroxine). L-thyroxine is the principal hormone secreted by the normal thyroid gland.



Sodium Levothyroxine

Actions

SYNTHROID (sodium levothyroxine) **Tablets,** taken orally, provide hormone that is readily absorbed from the gastrointestinal tract. SYNTHROID **Injection** is effective by any parenteral route. Following absorption, the synthetic L-thyroxine provided by SYNTHROID products cannot be distinguished from L-thyroxine that is endogenously secreted. Each is bound to the same serum proteins and each exhibits a six to seven day circulating half-life in the euthyroid individual.

Both SYNTHROID products will provide L-thyroxine as a substrate for physiologic deiodination to L-triiodothyronine. Therefore, patients taking SYNTHROID products will demonstrate normal blood levels of L-triiodothyronine even when the thyroid gland has been surgically removed or destroyed by radioiodine. Administration of levothyroxine alone will result in complete physiologic thyroid replacement.

Indications

SYNTHROID (sodium levothyroxine) products serve as specific replacement therapy for reduced or absent thyroid function of any etiology. SYNTHROID **Injection** can be used intravenously whenever a rapid onset of effect is critical, and either intravenously or intramuscularly in hypothyroid patients whenever the oral route is precluded for long periods of time.

Contraindications

There are no absolute contraindications to SYNTHROID (sodium levothyroxine) therapy. Relative contraindications include acute myocardial infarction, uncorrected adrenal insufficiency and thyrotoxicosis. (See WARNINGS)

Warnings

Patients with cardiovascular diseases warrant particularly close attention during the restoration of normal thyroid function by any thyroid drug. In such cases, low initial dosage increased slowly by small increments is indicated. Occasionally, the cardiovascular capacity of the patient is so compromised that the metabolic demands of the normal thyroid state cannot be met. Clinical judgment will then dictate either a less-than-complete restoration of thyroid status or reduction in thyroid dosage.

Endocrine disorders such as diabetes mellitus, adrenal insufficiency (Addison's disease), hypopituitarism and diabetes insipidus are characterized by signs and symptoms which may be diminished in severity or obscured by hypothyroidism. SYNTHROID (sodium levothyroxine) therapy for such patients may aggravate the intensity of previously obscured symptoms and require appropriate adjustment of therapeutic measures directed at these concomitant disorders.

Thyroid replacement may potentiate the effects of anticoagulants. Patients on anticoagulant therapy should have frequent prothrombin determinations when instituting thyroid replacement to gauge the need to reduce anticoagulant dosage.

Precautions

Overdosage with any thyroid drug may produce the signs and symptoms of thyrotoxicosis, but resistance to such factitious thyrotoxicosis is the general rule. With SYNTHROID (sodium levothyroxine) **Tablets,** the relatively slow onset of action minimizes the risk of overdose but close observation in the weeks following institution of a dosage regimen is advised. Treatment of thyroid hyperactivity induced by oral medication is confined to interruption of therapy for a week, followed by reinstitution of daily therapy at an appropriately reduced dosage.

Adverse reactions

Adverse reactions are due to overdose and are those of induced hyperthyroidism.

Dosage and administration

For most adults, a final dosage of 100 mcg (0.1 mg) to 200 mcg (0.2 mg) of SYNTHROID (sodium levothyroxine) **Tablets** daily will restore normal thyroid function and only occasionally will patients require larger doses. Failure to respond adequately to a daily oral intake of 400 mcg (0.4 mg) or more is rare and should prompt reconsideration of the diagnosis of hypothyroidism, special investigation of the patient in terms of malabsorption of L-thyroxine from the gastrointestinal tract or poor adherence to therapy.

The concomitant appearance of other diseases, especially cardiovascular diseases, usually dictates a replacement regimen with initial doses smaller than 100 mcg/day (0.1 mg).

In otherwise healthy adults with relatively recent onset of hypothyroidism, full replacement dose of 150 mcg (0.15 mg) or 200 mcg (0.2 mg) has been instituted immediately without untoward effect and with good therapeutic response. General experience, however, favors a more cautious approach in view of the possible presence of subclinical disorders of the cardiovascular system or endocrinopathies.

The age and general physical condition of the patient as well as the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage. In the elderly patient with long standing disease, evidence of myxedematous infiltration and symptomatic, functional or electrocardiographic evidence of cardiovascular dysfunction, the starting dose may be as little as 25 mcg (0.025 mg) per day. Further incremental increases of 25 mcg (0.025 mg) per day may be instituted at three to four week intervals depending on patient response. Conversely, otherwise healthy adults may be started at higher daily dosage and raised to the full replacement dosage in two to three weeks. Clearly it is the physician's judgment of the severity of the disease and close observation of patient response which determines the rate of dosage titration.

Laboratory tests to monitor thyroid replacement therapy are of limited value. Although measurement of normal blood levels of thyroxine in patients on replacement regimens frequently coincides with the clinical impression of normal thyroid status, higher than normal levels on oral replacement of levothyroxine occasionally occurs and should not be considered evidence of overdosage per se.

In all cases, clinical impression of the well-being of the patient takes precedence over laboratory determination in determining the appropriate individual dosage.

In infants and children, there is a great urgency to achieve full thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult, as much as 300 mcg (0.3 mg) to 400 mcg (0.4 mg) per day.

In myxedema coma or stupor, without concomitant severe heart disease, 200 to 500 mcg of SYNTHROID **Injection** may be administered intravenously as a solution containing 100 mcg/ml. Although the patient may show evidence of increased responsivity within six to eight hours, full therapeutic effect may not be evident until the following day. An additional 100 to 300 mcg or more may be given on the second day if evidence of significant and progressive improvement has not occurred. Like the oral dosage form, SYNTHROID **Injection** produces a predictable increase in the circulating level of hormone with a long half-time. This usually precludes the need for multiple injections but continued daily administration of lesser amounts intravenously should be maintained until the patient is fully capable of accepting a daily oral dose.

In the presence of concomitant heart disease, the sudden administration of such large doses of L-thyroxine intravenously is clearly not without its cardiovascular risks. Under such circumstances, intravenous therapy should not be undertaken without weighing the alternative risks of the myxedema coma and the cardiovascular disease. Clinical judgment in this situation may dictate smaller intravenous doses of levothyroxine.

SYNTHROID **Injection** by intravenous or intramuscular routes can be substituted for the oral dosage form when ingestion of SYNTHROID **Tablets** is precluded for long periods of time.

How supplied

SYNTHROID (sodium levothyroxine) **Tablets** are supplied as scored, color-coded compressed tablets in 6 concentrations: 25 mcg (0.025 mg)—orange . . . 50 mcg (0.05 mg)—white . . . 100 mcg (0.1 mg)—yellow . . . 150 mcg (0.15 mg)—violet . . . 200 mcg (0.2 mg)—pink . . . 300 mcg (0.3 mg)—green. Depending on strength, these tablets are available in bottles of 100, 500, 1000 and 5000.

SYNTHROID (sodium levothyroxine) for **Injection** is supplied in 10 ml vials containing 500 mcg of lyophilized active ingredient and 10 mg of Mannitol, U.S.P. A separate 5 ml vial containing Sodium Chloride Injection, U.S.P. is provided as a diluent.

Directions for reconstitution

Reconstitute the lyophilized sodium levothyroxine by aseptically adding 5 ml of the Sodium Chloride Injection, U.S.P. to the vial. Shake vial to insure complete mixing. **Use immediately** after reconstitution. Discard any unused portion.

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Practicing physicians fill void in medical school curriculum

RAYMOND W. CLUGH, M.R.PI.

THOMAS L. LEAMAN, M.D.

Hershey

To enable the students enrolled in The Milton S. Hershey Medical Center of The Pennsylvania State University to obtain a vital component of their education, the departments of family and community medicine, pediatrics, and medicine combined forces and talents to produce an effective and dynamic preceptorship program. A proposal was submitted to and funded by the Department of Health, Education and Welfare, Public Health Service. Basic objectives of the program are to offer first and second year students a realistic basis for future career decisions by providing some understanding of the critical needs, opportunities, difficulties, and satisfactions encountered in primary medical care. The third and fourth year students are to be provided in addition an in-depth comprehensive exposure to primary health care chiefly ambulatory in nature rather than hospital based. The time spent away from the medical school varies from one to two weeks for first and second year students to one to three months for third and fourth year students. All preceptees are expected to grasp fully the physician's position in society and to understand the patient-doctor relationship and how it is developed.

This paper was prepared by the directors of the Primary Care Preceptorship Program of The Milton S. Hershey Medical Center, Pennsylvania State University, Hershey. Mr. Clugh is the administrator of the program; Dr. Leaman is program director and chairman of the department of family and community medicine. Also contributing to the paper were Hiram L. Wiest, M.D., project director and assistant professor in the department of family and community medicine; John W. Burnside, M.D., departmental director and associate professor in the department of medicine; Nicholas M. Nelson, M.D., departmental director and chairman of the department of pediatrics; and Rugh A. Henderson, M.D., departmental director and assistant professor in the department of family and community medicine.

Responses received from preceptees have demonstrated quite clearly that exposure to the practice of medicine away from the "ivory tower" is appreciated and valuable. Several written opinions illustrate that belief. One student writes,

> The month I spent in a preceptorship in Bradford will certainly be one of the highlights of my medical education.

Another expression was,

> This experience gave me an excellent picture of what it is like to practice medicine in a small community and showed me that excellent medicine can be practiced even without every imaginable piece of equipment.

And finally,

> As a result of this preceptorship experience, I believe I have learned a great deal about clinical medicine, about dealing with patients as individuals, about the problems and rewards of this type of practice, and further concertized my own ideas about medical practice.

Method

The curriculum committee of the Milton S. Hershey Medical Center

has approved the Preceptorship Program as an elective course with the same academic credit and the same course number in the departments of family and community medicine, medicine, and pediatrics. In fact, the student may elect to participate in all three specialties, provided his schedule allows him sufficient elective time. Semester breaks are most popular among first and second year students while third and fourth year preceptees may schedule one to three month preceptorships throughout the calendar year. Third and fourth year preceptees are not permitted one to three month training periods unless they have completed the basic clerkships in medicine and pediatrics.

While engaging in the preceptorship, the preceptee is required to keep a daily log of practice contacts with brief notes of the essential demographic data, problems presented, and the plan of action undertaken. The preceptee is also required to write an evaluation of his preceptorship; that includes observations on the preceptor's ability to teach, relation to patients, hospitals and community agencies as well as utilization of staff. Practice management techniques are considered an important factor in the preceptee's report. The preceptor, on the other hand, is requested to evaluate the preceptee on a form designed and provided by the program staff.

In order that the preceptorship program can function in a uniform manner, despite differences in the individual style of practice employed by each preceptor, the staff has established the following guidelines:

1. The student is not to function as a physician's assistant; rather, he or she is to be treated as a student physician. The preceptee is not permitted to practice medicine except under the supervision of the preceptor.

2. This is to be primarily an office oriented training experience. The majority of the preceptee's time is to be spent in the doctor's office. The student is not expected to take independent action nor is he to take the place of the preceptor at any time.

3. The preceptor must present an honest demonstration of how he or she approaches, understands and manages patients through health maintenance, diagnosis, treatment and follow-up. Since the teaching takes place in the office, at a hospital bedside, and within the confines of a family environment, the preceptor must deal openly with the problems as they are presented.

4. Patients should be informed that the preceptee is a medical student studying under the guidance of their physician. Printed notices for display in the preceptor's reception room are provided to help the practicing physician to introduce the student to patients.

The preceptee is encouraged to reside in the preceptor's community throughout the preceptorship; for this reason, a daily stipend plus a modest mileage allowance is granted. In most cases, the program preceptor graciously invites the preceptee to reside in his home during the preceptorship. The informal atmosphere lends itself to informative discussions between teacher and student and permits the preceptee to be available to accompany the preceptor in case of emergency calls.

Personnel and locale

The program director supervises overall activities and maintains academic liaison with the office of the dean. Selection of personnel and implementation of major policies are two primary responsibilities shared by the program director and project director. The project director is available to the administrator at all times to confer on daily operations as well as administrative functions. Calling of program staff meetings and communicating with intrastate and interstate personalities are continuing responsibilities of the project director.

Departmental directors play a demanding role within the program by conducting initial interviews with and selection of preceptors. Quite often, these functions are performed in conjunction with the program administrator. Expertise in judging teaching skills is essential and some physicians are rejected as preceptors for various reasons. Students seek out the departmental directors for pre-preceptorship counselling and are required to make an appointment with their director for a discussion after completion of their preceptorships. Acting as advisors and resource personnel, the departmental directors work with the project director and administrator in the planning of the preceptor training conferences conducted each year. The continuing evaluation of the program is a top priority and to this end the directors counsel with the project director.

The program administrator is responsible for day to day operation of all project activities. His duties are included within four main areas: (1) general continuing project activities, (2) maintenance of project records, (3) project evaluation, and (4) planning and scheduling project activities. Monthly project summaries, annual reports, routine correspondence, and maintenance of preceptor and preceptee files are high on his list of priorities. The matching of student preferences with available preceptors, subject to departmental director approval, is an ongoing and vital function, along with frequent visits to preceptor sites.

Preceptors have been selected throughout the Commonwealth of Pennsylvania with the exceptions being the cities of Pittsburgh and Philadelphia. Since a main emphasis of the program is to attract physicians to rural area care, no effort was made to recruit preceptors in the large metropolitan areas. A total of 202 preceptors are presently enrolled and apportioned as follows: family medicine—101; internal medicine—46; and pediatrics—55. Our preceptors are graduates of medical schools from all sections of the country and few of them have ever experienced a preceptorship; therefore, they realize the full value of this experience for a medical student.

Annually, a preceptor training conference is held to improve the

teaching skills of practicing physicians and to provide feedback from the students. Speakers who are experienced in preceptorship activities present views of educational methods that have been effective in their hands. Students from the Hershey Medical Center who have experienced a preceptorship participate in a presentation based on "what they anticipated" and "what they received."

Results

There are 328 students enrolled in the College of Medicine at The Milton S. Hershey Medical Center. From the date of the first preceptorship, November 12, 1972, until the present, a total of 190 requests have been submitted by students. Keeping in mind that this course is an elective, the results demonstrated by student involvement are most gratifying. Of the current enrollment, 28 percent of the second year class, 42.1 percent of the third year class, and 71.6 percent of the fourth year class have sought primary care preceptorships. First year students are not encouraged to request a preceptorship until the completion of their freshman year. There have been 116 requests for preceptorships in family medicine, 40 in internal medicine, and 34 in pediatrics. Preceptees may and do seek training in more than one specialty. In fact, they are encouraged to make application for different experiences since there is a new opportunity for them each year.

Evaluation

Preliminary studies seem to support the concept that an apparent void in The Pennsylvania State University College of Medicine's curriculum has been filled by the preceptorship program. Students appreciate the opportunity to observe and study the vast spectrum of illnesses that typify total ambulatory patient care. Another important aspect of the program is that a continuing study is underway to determine the long range effectiveness of this program in attracting physicians to rural areas of Pennsylvania.

As an additional bonus, many preceptors express gratification for the opportunity to teach medical care. Many emphasize that they now realize how much they had forgotten; they are constantly appraised through contact with their students. They have received the necessary stimulus to increase their capabilities by continuing their own education.

Support for this program was obtained from the Department of Health, Education and Welfare, Public Health Service, under Grant Number 03D005050

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124th AMA Annual Convention
June 14-18, 1975
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Scientific Program

It's a new day at AMA Annual Conventions! The entire thrust of the 1975 scientific program is on accredited continuing medical education. Category I Credit will be given for almost all programs—even for many of the scientific exhibit features. The commercial exhibits are business-like, to provide information to you if it is wanted. The entire program consists of postgraduate courses, general and specific symposia, scientific exhibits, commercial and industrial exhibits, and motion picture symposia on the most relevant subject matter for today's practicing physician. Active physician participation in discussions is encouraged at *every* session.

In every postgraduate course in which it is relevant, syllabi will be given for study and reference at home. Self-assessment tests of information presented during symposia may be expected—just for the individual's own edification. For verification of attendance for continuing medical education credit, individual record cards will be punched for each accredited session attended.

Hotelevision, Continuing Medical Education in your hotel room! Medical education courses will be offered nightly on Hotelevision for Category I Credit. Self-assessment post-tests will certify participation for credit toward your AMA Physician's Recognition Award. Television course topics via closed-circuit TV will include: Office Orthopedics, Office Diagnosis and Management of Depression, Problems in Diabetes Management, and Hypertension.

General Program—Scientific Courses and Special Activities

FRIDAY, JUNE 13 • 8:00 AM-Noon & 1:15-6:00 PM and SATURDAY, JUNE 14 • 8:00 AM-Noon & 1:15-5:00 PM, 2-DAY CONFERENCE; Category I Credit, 16 hours: $40, or $20 for 1-Day or Student Rate

53. 1st National Conference on the Mental Health Aspects of Sports, Exercise, Recreation—1st Day

54A. 1st National Conference on the Mental Health Aspects of Sports, Exercise, Recreation—2nd Day

54B. SATURDAY, JUNE 14 • Luncheon and Speaker Joe Paterno, Penn State University head coach; Noon hour; Theme—Mental Health Aspects of Sports: Luncheon Fee Alone: $7.00

SATURDAY, JUNE 14 • Courses Nos. 45 & 46 are Category I Credit, 5 hours each: $45

45. Basic Life Support—Cardiopulmonary Resuscitation • *Section One, 8:00 AM-12:30 PM*
46. Basic Life Support—Cardiopulmonary Resuscitation • *Section Two, 1:00-5:30 PM*

SATURDAY, JUNE 14 • 9:00 AM-5:00 PM and SUNDAY, JUNE 15 • 9:00 AM-Noon; Category I Credit, 11 hours: $110

51. Postgraduate Course in Public Speaking

SATURDAY, JUNE 14 • Courses Nos. 1-12 & 52 are Category I Credit, 6 hours each; 9:00 AM-Noon & 2:00-5:00 PM: $60 each

1. Acid-Base, Fluid, and Electrolyte Balance
2. Antibiotics—The Proper Selection
3. Current Concepts in Drug Therapy
4. Cutaneous Surgery for the Dermatologist
5. How to Sew (Principles of Suture Techniques)
6. Human Sexuality *(Physicians & Spouses)*
7. Management of Acute Respiratory Failure
8. Management of the Multiply Injured Patient
9. Office Gynecology
10. The Long-Term Treatment of Asthma
11. The Neurological Examination
12. Total Care of the Burn Patient

52. Writing for Scientific Journals

SATURDAY, JUNE 14 • Courses Nos. 13 & 14 are Category I Credit, 4 hours each; $40 each

13. Basic Electrocardiography *(8:00 AM-Noon)*
14. Cardiac Arrhythmia: Diagnosis and Management *(1:00-5:00 PM)*

SATURDAY, JUNE 14 • Courses Nos. 15-17 are Category I Credit, 3 hours each: $30 each

15. Radioimmunoassay in Diagnostic Medicine *(9:00 AM-Noon)*
16. Management of Emotional Problems in Allergy *(2:00-5:00 PM)*
17. The Management of Stroke *(2:00-5:00 PM)*

SUNDAY, JUNE 15 • Category I Credit, 5 hours: $45

47. Basic Life Support—Cardiopulmonary Resuscitation • *Section Three, 8:00 AM-12:30 PM*

SUNDAY, JUNE 15 • Courses Nos. 18-30 are Category I Credit, 6 hours each; 9:00 AM-Noon & 2:00-5:00 PM: $60 each

18. Acid-Base, Fluid, and Electrolyte Balance
19. Advances in Diagnosis and Treatment of Gastrointestinal Malignancies
20. Dermatology for Non-Dermatologists
21. Diagnosis and Management of Renal Diseases
22. How to Sew (Principles of Suture Techniques)
23. Human Sexuality *(Physicians Only)*
24. Office Management of Adolescents
25. Office Management of Mental Health Emergencies
26. Office Urology for Non-Urologists
27. Ophthalmoscopy for Non-Ophthalmologists
28. Rational Use of Drugs
29. The Neurological Examination
30. Trauma of the Hand

SUNDAY, JUNE 15 • Courses Nos. 31-36 are Category I Credit, 3 hours each: $30 each

31. Common Household Toxins and Poisons *(9:00 AM-Noon)*
32. Radiology of the Chest *(9:00 AM-Noon)*
33. The Management of Stroke *(9:00 AM-Noon)*
34. Pacemakers *(2:00-5:00 PM)*
35. Radioimmunoassay in Diagnostic Medicine *(2:00-5:00 PM)*
36. The Surgical Patient—Pre-Operative Evaluation and Post-Operative Care—Anesthesiology *(2:00-5:00 PM)*

SUNDAY, JUNE 15 • 1:30-5:00 PM and MONDAY, JUNE 16 • 9:00 AM-Noon & 1:30-5:00 PM, Category I Credit, 10 hours: $100

49. Advanced Life Support—Cardiopulmonary Resuscitation (Prerequisite: Basic Life Support) • *Sequence One*

SUNDAY, JUNE 15 through WEDNESDAY, JUNE 18/Register for any of 6 pathology courses with ASCP (See Special Activities)

- **SCIENTIFIC EXHIBITS (See Special Activities)**
- **FILM SYMPOSIA (See Special Activities)**

MONDAY, TUESDAY, & WEDNESDAY, JUNE 16-18 • Courses Nos. 37-44 are Category I Credit, 5 hours each; 7:30-9:00 AM for these 3 days: $45 each course

37. Chronic Infections of the Lung and Pleural Effusion
38. Clinical Diagnosis of Muscular Weakness
39. Clinical Occupational Medicine for Community Physicians
40. Emergency Pediatric Care
41. Fluids and Electrolytes in Children
42. Management of Soft Tissue Injuries
43. Office Management of Anorectal Disease
44. Team Approach to Rheumatoid Arthritis

TUESDAY, JUNE 17 • Category I Credit, 5 hours: $45

48. Basic Life Support—Cardiopulmonary Resuscitation • *Section Four, 8:00 AM-12:30 PM*

TUESDAY, JUNE 17 • Luncheon-Seminar • 1:00-4:00 PM (See Special Activities)

- Science and Ideals in a Hungry World

TUESDAY, JUNE 17 • 1:30-5:00 PM and WEDNESDAY, JUNE 18 • 9:00 AM-Noon & 1:30-5:00 PM, Category I Credit, 10 hours: $100

50. Advanced Life Support—Cardiopulmonary Resuscitation (Prerequisite: Basic Life Support Course) • *Sequence Two*

Special Activities

Basic Life Support – Cardiopulmonary Resuscitation/Offered 4 times, once in each of 4 Sections/Courses Nos. 45, 46, 47, & 48*

Advanced Life Support – Cardiopulmonary Resuscitation (Prerequisite: Basic Life Support Course)/Offered in 2 Sequences/Course Nos. 49 & 50*

Postgraduate Course in Public Speaking/ Course No. 51*

Speaking skills such as message preparation, speech delivery, and the art of fielding questions will be honed sharply by the expert faculty for this course. Each registrant will receive personal coaching and can see his own presentation through television playbacks.

Writing for Scientific Journals/Course No. 52*

In cooperation with the American Medical Writers Association, the AMA Council on Scientific Assembly will again present a practical, helpful medical writing seminar. Writing assignments are given before and during the seminar so that practical experience and expert direction may be gained by all in attendance.

1st National Conference on the Mental Health Aspects of Sports, Exercise, and Recreation/ Activities Nos. 53 & 54A*

Mental health and the humanistic dimensions of sports, exercise, and recreation; the first day – organized sports and the young, and the second day – exercise and recreation related to adults and aging. Co-sponsored by AMA's Committee on Medical Aspects of Sports, Council on Mental Health, and Council on Scientific Assembly.

Concepts of Primary Care and the Role of Joint Practice/Sunday, June 15/7:30-10:00 PM

Concepts of primary care and the role of joint practice will be discussed from both a medical and nursing point of view: a physician-nurse team will describe their private joint practice. A nurse-physician reaction panel will comment on the presentation. This special joint activity will be held in the Atlantic City Holiday Inn in cooperation with the National Joint Practice Commission of the American Medical Association and the American Nurses' Association.

American Society of Clinical Pathologists' Courses/Sunday, June 15 – Wednesday, June 18 (Category I Credit, 3 hours; $40 for each of the six courses essentially for non-patholgists listed below:

Morphology of Smears and Bone Marrow Sections; Practical Aspects of Blood Component Administration; Analyses of Amniotic Fluid in Pregnancy at Risk; Combined Isoenzyme Diagnosis of Myocardial Infarction; How to Avoid Being Misled by Your Microbiology Laboratory; and The Concept of Cure in Hodgkins Disease. Correspondence, fees, and application for these courses, which are co-sponsored by the American Society of Clinical Pathologists and the American Medical Association, should be sent directly to the *American Society of Clinical Pathologists, 2100 W. Harrison Ave., Chicago, IL 60612*, or phone *(312) 738-1336.*

Fireside Forums

Brief videotape presentations will depict up-to-date advances in important areas of clinical medicine; all faculty members participating will be present for informal follow-on discussions at these evening programs. Refreshments will be served; no registration fee. Topics and institutions represented are: Diagnosis and Management of Rheumatoid Disease (University of Chicago), Diagnosis and Management of Peripheral Vascular Disease (Northwestern University Medical School, Chicago), Current Diagnosis and Management of Alcoholism (Rush Medical School, Chicago) To be held in Holiday Inn in Atlantic City, N.J.

Science and Ideals in a Hungry World: Luncheon-Seminar

Luncheon-Seminar presented cooperatively by the Woman's Auxiliary to the AMA and the AMA Council on Scientific Assembly on Tuesday, June 17 – 1:00-4:00 PM at Howard Johnson Hotel, Atlantic City, N.J. Speakers will be renowned authorities, Rene Dubos, PhD, and Mona Doyle, Food Fair Stores, Inc., consumer affairs director. Auxiliary members and their guests are invited to a wide range of other activities – such as the *1st National Conference on the Mental Health Aspects of Sports, Exercise, and Recreation, Estate Planning for Physicians and Their Families*, and the general session on *Sexual Enrichment.*

Tickets and information on the luncheon-seminar, tours, and other Auxiliary Convention events are available from the *Woman's Auxiliary to the AMA, 535 N. Dearborn St., Chicago, IL 60610.*

The Youth Activities Program

Also offers tours for the physician's family that will preview the bicentennial celebrations of 1976. For details, write: *Combined World Travel, 21 E. Van Buren St., Chicago, IL 60605.*

Scientific Exhibits include Fractures/Live Teaching Clinics/Cardiopulmonary Resuscitation (CPR)/Heart Sound Recognition/Pulmonary Function*

Film Symposia include outstanding medical teaching films*

*For replies to all questions about the above Special Activities asterisked and their registration information, write directly to: *AMA's Circulation & Records, 535 N. Dearborn St., Chicago, IL 60610*

Sessions

AMA Sections have prepared these meetings. Most of the following symposia will be accredited as Category I Continuing Education for the AMA Physician's Recognition Award (to be indicated in the official program). All other sessions will bear Category II Credit.

MONDAY, JUNE 16 • 9:00 AM-Noon

- Acute Myocardial Infarction: Pre-Hospital, Hospital, and Post-Hospital Phase *(first half session)*
- Troublesome Complications Following Intestinal Surgery
- The Sexually Transmitted Diseases: A Clinical Update
- Management of Sexual Problems by the Family Physician
- Coma
- Ophthalmology *(general papers)*
- Orthopedic Surgery *(general papers)*
- Urology *(general papers)*
- Role of the Medical Director in the Skilled Nursing Facility *(first half session)*

MONDAY, JUNE 16 • 2:00-5:00 PM

- Acute Myocardial Infarction: Pre-Hospital, Hospital, and Post-Hospital Phase *(second half session)*
- Narcotics: Actions, Antagonists, Addiction
- Lesions of the Colon Involving Pelvic Organs
- The Contributions of Ophthalmic Pathology to Advances in Eye Surgery
- Antibiotic Therapy in Children
- Dermatology *(general papers)*
- Orthopedic Surgery *(general papers)*
- Role of the Medical Director in the Skilled Nursing Facility *(second half session)*

TUESDAY, JUNE 17 • 9:00 AM-Noon

- A Unified Approach to Emergent Problems: Multiple Trauma/Acute Myocardial Infarction *(first half session)*
- Changing Concepts in the Management of Peptic Ulcer Disease
- Communication Disorders in the Non-Deaf Child
- Tricks, Tips, Traps, and Techniques – Common Problems in Management, How I Do It
- Office Treatment of Depression
- The Federal Thrust in the Organization of Health Care
- General Surgery *(general papers)*
- Ophthalmology *(general papers)*
- Dermatology *(general papers)*

TUESDAY, JUNE 17 • 2:00-5:00 PM

- A Unified Approach to Emergent Problems: Multiple Trauma/Acute Myocardial Infarction *(second half session)*
- Immunofluorescent Tests in Diagnosis and Diseases of Skin, Eye, and Mucous Membranes
- Gas and Constipation – The Constant Enigma
- Carcinoma of the Breast
- Trauma: Potentiation by Alcohol
- Panel on the Tonsil and Adenoid Dilemma
- Maxillofacial Trauma
- Regulation of Therapeutics: Package Inserts and Their Significance to Physician, Patient, and Pharmacist
- Ophthalmology *(general papers)*

WEDNESDAY, JUNE 18 • 9:00 AM-Noon

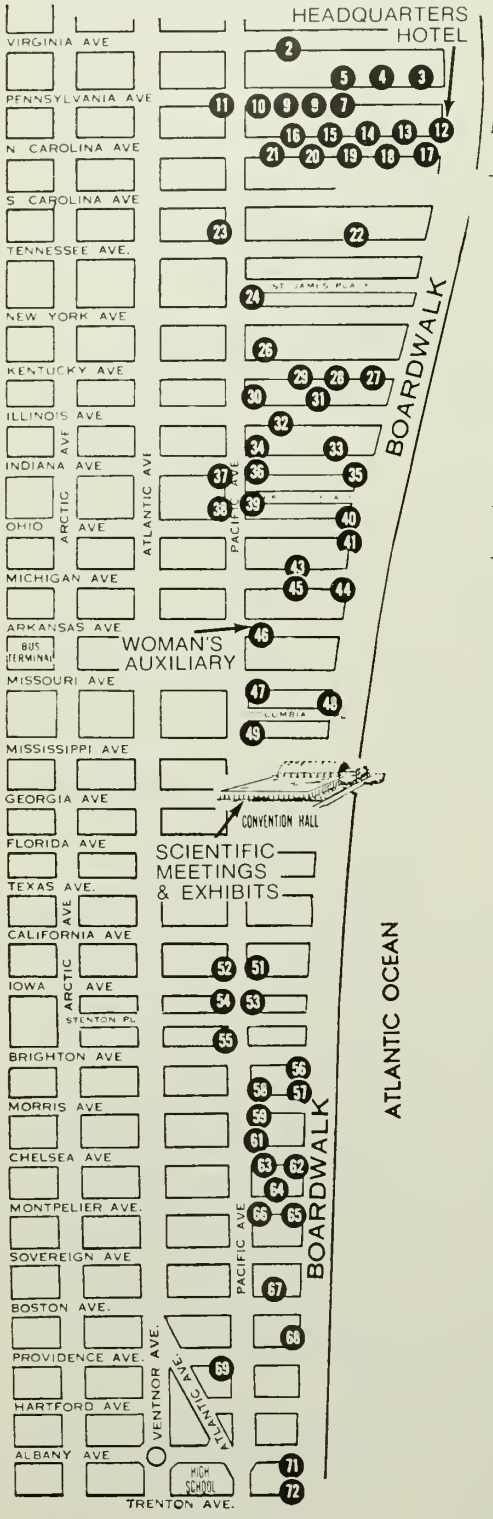
- The Troublesome Nose: What Causes It and What to Do About It
- Changing Patterns in Mechanical Ventilation
- Special Problems in Skin Infection
- Diagnostic Tools in Pediatric Urinary Tract Disease *(first of two 1½-hour panels)*
- Management of Abnormalities of the External Genitalia *(second of two 1½-hour panels)*
- Transsexualism: A Multispecialty Approach
- Pets and Human Diseases: What's the Risk? (In cooperation with the American Veterinary Medical Association)

WEDNESDAY, JUNE 18 • 2:00-5:00 PM

- Differential Diagnosis of Bronchospastic Disorders
- The Operating Room in the 1970s
- Medical Hazards of Travel
- Current Practices in Cancer Chemotherapy
- Sexual Enrichment

124th AMA Annual Convention
June 14-18,1975/Atlantic City, N.J.
Housing Form

AMA Housing Bureau
c/o The Atlantic City Convention Bureau
16 Central Pier
Atlantic City, NJ 08401



Map No.	HOTELS	Rooms with Bath: Single	Rooms with Bath: Twin/ Double	Lanai/ Villa +Twins	Two Rooms/ One Bath: 2	3	4 Per.	Parlor Suites: 1 B/rm.	2 B/rm.
12	Chalfonte-Haddon Hall (A,B,C,D)	**HDQ. HOTEL**			(NO RMS.)				
19	Carolina Crest (F)	$13-17	$17-23						
35	Claridge (A,B,C)	20-32	24-45					$125	
10	Colton Manor (A,B,C,D,E)	20-26	22-32					61	$89
38	Eastbourne (E,F)	18	20-22		$28	$32			
48	Holiday Inn (A,B,C,D,E,F)	22-34	32-44					78-88	98-160
46	Howard Johnson's (A,B,C,D,E,F)	30-34	32-46	$56				104-112	182
29	Jefferson (A,B,F)	14-16	16-20			27	$32		
62	LaConcha (A,B,C,D,E,F)	20-28	24-32	45				56	84
41	Marlborough-Blenheim (A,B,C,D,E)	22	28-35					63-70	
13	Ramada Inn (A,B,C,D,E,F)	30-42	32-44	44				90	
44	Shelburne-Empress (A,B,C,D,E)	19-42	21-45					64-82	92-150
56	Sheraton-Deauville (A,B,C,D,E,F)	20-30	24-32					60	90-150
3	Sheraton-Seaside (A,B,C,D,E,F)	22-26	26-34			45		104	
28	Sterling (F)	18-20	22-24						
	MOTELS								
26	Acapulco (E,F)	$18	$20-24						
58	Algiers (A,B,C,D,E,F)	20-22	24-32	$25-35				$ 65-70	$90
64	Aloha (E,F)	18-22	24-28	30-34					
7	Aristocrat (E,F)	14-20	18-26						
51	Ascot (E,F)	24	24-32					45	
32	Bala (D,E,F)	16-28	18-32						
18	Barbizon (E,F)		24-32						
15	Barclay (D,E,F)	18-22	22-32	34				80	
36	Best Western Crillon (D,F)	21-27	23-33					70-80	90-100
21	Burgundy (E,F)	16-18	16-28						
20	Carolina Crest (F)		23-25						
59	Castle Roc (E,F)	14	18						
17	Catalina (E,F)		24-32						
33	Colony-Best Western (A,B,C,D,E,F)	20-36	20-40					75	105-115
9	Colton Manor (A,B,C,E,F)		31-37					75	105
31	Continental (B,E,F)	18-28	20-32						150
11	Crown (F)	20	24-28						
43	Dennis (A,B,C,D,E,F)		24-42						
53	Diplomat (E,F)	18-26	24-30	32-36				65	
55	Dunes (E,F)	20-24	25-27						
37	Eastbourne (E,F)	22-26	24-28	30-35					
52	Eldorado (F)	20	24						
66	El Greco (F)		22						
24	Envoy (F)		20-24						
23	Fiesta (A,E,F)		28						
47	Four Seasons (D,E,F)	24-28	28-36						
54	Galaxie (E,F)	18	20-22						
16	LaFayette (A,B,C,D,E,F)	18-38	20-40					50-90	120-150
72	Lincoln Roosevelt Beach (E,F)	14	15-24	16-24					
27	Lombardy (A,D,E,F)	17-29	20-35						
65	Malibu (E,F)		18-32						
40	Marlborough-Blenheim (A,B,C,D,E)		32-34	39				66	
34	Midtown (A,B,C,D,E,F)	20-26	22-36					80	120
39	Mt. Royal (A,D,E,F)	18-30	21-39						
69	New Nautilis (E,F)	22	26						
49	Pageant (A,B,C,D,E,F)	22-30	26-36						
71	President (A,B,C,D,E,F)	24-32	29-40						
14	Ramada Inn (A,B,C,D,E,F)	22-30	24-32						
8	Sahara (B,E,F)	10-18	16-24						
2	St. Moritz (F)	18-20	22-24						
45	Shelburne-Empress (A,B,C,D,E,F)	19-42	21-42					64-82	92-150
57	Sheraton-Deauville & Sheraton-Deauville West (A,B,C,D,E,F)	26-32	28-34	36-40				90	120-150
4	Sheraton-Seaside (A,B,C,D,E,F)	24-28	26-34						108
30	Sorrento (E,F)	24-26	26-30						
68	Strand (A,B,D,E,F)	32	36					90	
61	Teplitzky's (A,C,D,E,F)	20-22	24-36					90	
5	Terrace (A,B,C,D,E,F)	24-28	26-34					72	
22	Trinidad (B,E,F)	20	24						
67	Tropicana (A,E,F)	20	26-28						

A Restaurant and/or Coffee Shop
B Cocktail Lounge and Bar
C Room Service
D All-Year Pool
E Outdoor Pool
F Rate Includes Parking/Kitchenette Facilities Available – Rates on Request

The Above Rates are subject to 5% Municipal Tax

For Room Reservations

AMA 124th Annual Convention June 14-18, 1975
AMA Housing Bureau
c/o The Atlantic City Convention Bureau
16 Central Pier
Atlantic City, NJ 08401

Please print or type five choices:

1st _____

2nd _____

3rd _____

4th _____

5th _____

Please enter my reservation at the above hotel/motel for: Single(s) ___ @ $_____ Twin/Double(s) ___ @ $_____

1 Bedroom **Suites** 2 Bedroom
___ @ $_____ ___ @ $_____

(Detach, fill out, and return this form with your remittance.)

Please add 5% for the Municipal Tax; if your rate requested is not available, the next highest rate will be assigned. DO NOT send your request directly to the hotel, it will only delay your confirmation. Kindly make all necessary changes and cancellations directly with the Housing Bureau, and be sure and specify your time of arrival, as well as the date. If you are an Industrial Exhibitor, please specify your firm's name and the list of all the occupants for all the rooms you are reserving.

Confirmations will be mailed up to June 2, 1975.

Room will be occupied by:

Name (Please print or type) _____

Address _____

City/State/Zip _____

Additional Occupants (list ages of children)

_____

Arrival Date _____ at _____ AM PM Departure Date _____

Registration Form — Courses

Please send your postgraduate course registration coupon below to us by May 5, 1975. Tickets and registration materials will be sent to you on May 19, 1975, unless you request an earlier mailing date. Course tickets requested after May 5, 1975, may be picked up at the Postgraduate Course Registration Desk in the Atlantic City, N.J., Convention Hall. Please use the corresponding number for each course to indicate your choices for each day, in order of preference, in the spaces provided on the returnable coupon. Try to avoid choices which conflict. If the minimum course registration is not attained for your first choice, or if the course is full, one of your alternate choices will be substituted. *Note: All medical students, interns, and residents are entitled to a 50% discount on registration fees.*

Advance Registration

124th AMA Annual Convention
Atlantic City, N.J.
Convention Hall
June 14-18, 1975

Please return to:
American Medical Association
Circulation & Records Dept.
535 N. Dearborn St.
Chicago, IL 60610

General Registration

_____ AMA members and their guests: no fee
_____ Non-member physicians: $35
_____ Guests of non-members: $10
_____ Medical students, interns, residents, and foreign physicians: no fee

To receive your Advance Registration Card, this form must arrive at the AMA by May 5, 1975. (After this date, please register at the Convention Hall in Atlantic City, N.J.) Your Advance Registration Card will be sent to you on May 19, 1975, unless you request an earlier mailing date.

My remittance of $_____ is enclosed. I have submitted herewith a check (or money order) payable to the American Medical Association to cover the registration and courses' fees that I have indicated on this form.

Name _____
Please print (Each physician must register in his/her own name.)

Office Address _____

City/State/Zip Code _____

Office Phone No. (_____)_____ (Postgraduate Course Registrants Only)

I am a member of the AMA through the following State Medical Association or government service _____

In accordance with the AMA Bylaws, I hold active membership in the AMA, and I wish to vote in the Scientific Section that I have checked:

01 ☐ Allergy
02 ☐ Anesthesiology
26 ☐ Cardiovascular Diseases
05 ☐ Clinical Pharmacology and Therapeutics
20 ☐ Colon and Rectal Surgery
03 ☐ Dermatology
04 ☐ Diseases of the Chest
07 ☐ Family and General Practice
11 ☐ Federal and Military Medicine
06 ☐ Gastroenterology
08 ☐ General Surgery
09 ☐ Internal Medicine
24 ☐ Neurological Surgery
25 ☐ Neurology
13 ☐ Obstetrics and Gynecology
14 ☐ Ophthalmology
15 ☐ Orthopedic Surgery
10 ☐ Otorhinolaryngology
16 ☐ Pathology
17 ☐ Pediatrics
18 ☐ Physical Medicine and Rehabilitation
27 ☐ Plastic, Reconstructive and Maxillofacial Surgery
19 ☐ Preventive Medicine
12 ☐ Psychiatry
21 ☐ Radiology
22 ☐ Urology

Postgraduate Course Registration Coupon

NOTE: All medical students, interns, and residents are entitled to a 50% discount on course registration fees.

FRI., JUNE 13 & SAT., JUNE 14 ($40, or $20 for 1-day or student rate)
#53 (1st Day) _____
#54A (2nd Day) _____

SAT., JUNE 14 • LUNCHEON + SPORTS SPEAKER JOE PATERNO; Noon Hour = $7.00
#54B _____

SAT., JUNE 14 • BASIC CPR = $45/5 hrs.
#45 (Section One) _____
#46 (Section Two) _____

SAT., JUNE 14 & SUN., JUNE 15 • $110
#51 _____

SAT., JUNE 14 • #1-12 & 52 = $60/6 hrs.
List your preference:
1st Choice: # _____
2nd Choice: # _____
3rd Choice: # _____

SAT., JUNE 14 • MORNING COURSES: #13 = $40/4 hrs. & #15 = $30/3 hrs.
1st Choice: # _____
2nd Choice: # _____

SAT., JUNE 14 • AFTERNOON COURSES: #14 = $40/4 hrs., #16 & #17 ea. = $30/3 hrs.
1st Choice: # _____
2nd Choice: # _____

SUN., JUNE 15 • BASIC CPR = $45/5 hrs.
#47 (Section Three) _____

SUN., JUNE 15 & MON., JUNE 16 • ADVANCED CPR = $100/10 hrs.
#49 (Sequence One)

SUN., JUNE 15 • #18-30 ea. = $60/6 hrs.
List your preference:
1st Choice: # _____
2nd Choice: # _____
3rd Choice: # _____

SUN., JUNE 15 • MORNING COURSES: #31-33 ea. = $30/3 hrs.
1st Choice: # _____
2nd Choice: # _____

SUN., JUNE 15 • AFTERNOON COURSES: #34-36 ea. = $30/3 hrs.
1st Choice: # _____
2nd Choice: # _____

MON., TUES., & WED., JUNE 16-18: 3-day courses, #37-44 ea. = $45/5 hrs.
1st Choice: # _____
2nd Choice: # _____
3rd Choice: # _____

TUES., JUNE 17 • BASIC CPR = $45/5 hrs.
#48 (Section Four) _____

TUES., JUNE 17 & WED., JUNE 18 • ADVANCED CPR = $100/10 hrs.
#50 (Sequence Two)

TUES., JUNE 17 • Luncheon-Seminar
Check Here If Interested in Luncheon & Afternoon Seminar • "Science and Ideals in a Hungry World": _____

SUN., JUNE 15 through WED., JUNE 18: ASCP/AMA-sponsored 6 pathology courses for non-pathologists; each = $40/3 hrs./ Register with ASCP.

SUN., JUNE 15 • SPECIAL JOINT ACTIVITY WITH AMA's & ANA's NJPC • 7:30-10:00 PM • HOLIDAY INN
No fee

MON., JUNE 16 through WED., JUNE 18: Sessions: No fee

WOMAN'S AUXILIARY TO THE AMA: For all their programs, write direct

FINAL CONVENTION DETAILS: Check the Convention Issue of the Journal of the American Medical Association • April 28

Gallstone ileus

LEE S. SERFAS, M.D.
A.M. JANDALI, M.D.
Easton

Dr. Serfas is director of surgery at Easton Hospital. He is associate professor of surgery at Hahnemann Medical College and Hospital and is certified by the American Board of Surgery and the Board of Thoracic Surgery. Dr. Jandali was chief surgical resident at Easton Hospital at the time this paper was written. He has since returned to Syria.

Gallstone ileus is a mechanical obstruction of the gastrointestinal tract caused by a gallstone. It is a relatively rare entity. Gallstones are the cause of intestinal obstruction in 1-2 percent of cases of intestinal obstruction.[1,2] The incidence is higher in nonstrangulating obstruction in patients over the age of 65.[2,3] Less than 1 percent of patients with cholelithiasis develop gallstone ileus. Approximately 80-90 percent of gallstones that enter the intestine will pass spontaneously;[4] 6-14 percent of patients with biliary intestinal fistulas develop gallstone ileus; and 90 percent of these fistulas are associated with cholelithiasis.[5] Other causes of fistulas are peptic ulcers and neoplasms. The F/M ratio is about 14/1.

Clinical data

From 1960 through 1972 there were 2,183 cholecystectomies performed, but only twelve cases of gallstone ileus at Easton Hospital. Four cases will be presented in detail with demonstration of the x-ray findings in eleven cases.

Case 1—This 55-year-old white female was admitted complaining of nausea, vomiting, and abdominal pain of six days' duration. In 1960 she had closure of a perforated gastric ulcer and in 1966 gastric resection for bleeding duodenal ulcer. She denied previous history of gallbladder disease or jaundice. Laboratory data revealed a markedly elevated alkaline phosphatase, elevated serum glutamic oxaloacetic transaminase, leukocytosis with a shift to the left, and a normal serum bilirubin. X-ray of the abdomen revealed mechanical small bowel obstruction with pneumobilia. (Figure 1). The gallstone causing obstruction was not visible. A preoperative diagnosis of gallstone ileus was made, and this was confirmed at laparotomy when one stone, measuring 4x3 cm, was found impacted in the upper ileum. A search for other stones was negative. The stone was removed through an enterotomy incision. The patient did well and was discharged on the tenth hospital day.

Case 2—This 67-year-old white male was admitted with a five-day history of nausea, vomiting, and hiccups. He had lost 20 pounds in weight over the previous five months but denied any history of

Figure 1. Case 1 - Mechanical small bowel obstruction and pneumobilia.

Figure 2. Case 2 - Proximal small bowel obstruction, opaque gallstones, and penumobilia. Obstructing stone not visible.

Figure 3. Case 2 - External appearance of obstructed jejunum at surgery. Gallstone outline is visible with proximal distention.

Figure 5. Case 3 - Small bowel obstruction, penumobilia and arrows point to large gallstone obstructing the jejunum.

abdominal pain, jaundice, or gallbladder disease. Laboratory work-up revealed a blood urea nitrogen of 58 mgm/100 ml and a bilirubin of 3.1 mgm/100 ml. Abdominal films showed minimal small bowel gas, questionable air in the biliary tract, and opaque stones in the gallbladder area (Figure 2). The gallstone causing obstruction was not visible. A preoperative diagnosis of small bowel obstruction was made, and at laparotomy a large gallstone was found impacted in the jejunum (Figure 3). Enterolithotomy was performed (Figure 4). The patient developed a wound infection, followed by evisceration on the sixth postoperative day which was closed with through and through retention sutures. He was discharged on the twenty-first hospital day.

Case 3—A 66-year-old white female was admitted with a history of sudden onset of abdominal pain one week prior to admission, followed by nausea and feculent vomiting. She developed bloody diarrhea the day prior to admission. She denied history of biliary colic or jaundice. She had had frequent attacks of recurrent bronchitis and had rheumatoid arthritis. Serum bilirubin was normal. White blood cell count, blood urea nitrogen, and blood sugar were elevated. Abdominal x-ray revealed an opaque gallstone in the right upper quadrant and pneumobilia (Figure 5). At laparotomy a 6x4 cm gallstone was removed from the distal jejunum (Figure 6). The wound was left open, but it became infected with bacteroides. The patient was discharged on the eleventh hospital day. A year later she was re-admitted because of sudden abdominal pain, vomiting, and fever. An intravenous cholangiogram showed fair visualization of a normal-appearing common bile duct with no evidence of stone or obstruction. The patient was jaundiced, with a serum bilirubin ranging between 4-7 mgm/100 ml. A diagnosis of ascending cholangitis was made. She was treated with tetracycline, following which she improved rapidly and was discharged. A year later she was admitted with a six-week history of intermittent fever. Liver scan revealed generalized decreased uptake. Exploration revealed extensive adhesions of the right upper quadrant and a liver studded with neoplastic

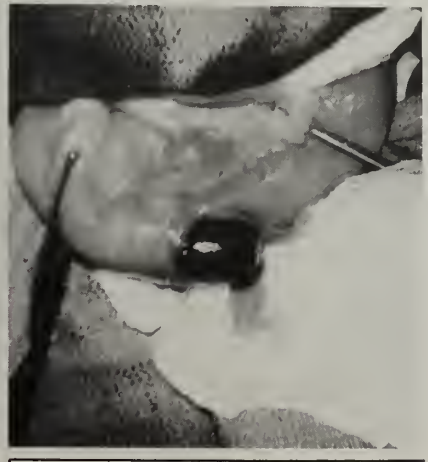


Figure 4. Case 2 - Large obstructing gallstone being removed by enterolithotomy.

Figure 6. Case 3 - Large gallstone being removed from jejunum by enterotomy.

implants. A liver biopsy was done which showed poorly differentiated carcinoma. She was referred to the oncologist for chemotherapy.

Case 4—An 80-year-old white female was admitted with a two-day history of vague abdominal pain, nausea, and vomiting. She was suffering from chronic organic brain syndrome, arteriosclerotic and chronic congestive heart disease. As far as could be determined, there was no previous history of abdominal pain or jaundice. Laboratory work-up revealed leukocytosis with a shift to the left. The admitting impression was appendicitis. She was placed on ampicillin while being hydrated, digitalized, and her electrolytes corrected. X-ray revealed air in the biliary system with distention of the proximal duodenum with a fluid level (Figure 7).

Figure 7. Case 4 - Air fluid level in duodenum with pneumobilia which was appreciated only in retrospect.

At laparotomy a large 3x4 cm stone was obstructing the jejunum and was removed through an enterotomy incision. Two small stones were palpated in the duodenum and upper jejunum and were milked distally and removed from the jejunotomy site. The patient was continued on ampicillin. She developed a wound infection and phlebitis. She was discharged on the eleventh postoperative day and has had no recurrence.

Results

Pertinent x-rays were available in eleven of our cases, four of which have been demonstrated. The remaining seven cases are demonstrated in Figures 8 through 15.

In our twelve cases the average age was seventy-four and the F/M ratio 3/1. Associated diseases—diabetes mellitus in five, arteriosclerotic heart disease with cardiac failure in four, obesity in six, encephalopathy in three, abnormal electrocardiogram in nine and hypertension in three patients. History of gallbladder disease was obtained in only two of our twelve patients.

The onset of symptoms was subacute (over a period of two to five days) in nine patients and acute in three patients. The presenting symptoms were nausea, vomiting, and abdominal pain in all patients. Leukocytosis was found in ten, elevated blood urea nitrogen in five, elevated alkaline phosphatase in four, elevated serum bilirubin in three, and elevated amylase in two.

Air in the biliary tree was recognized preoperatively in only five patients, but in retrospect pneumobilia was present in ten patients on preoperative plain films of the abdomen. The obstructing gallstone was opaque in three patients.

Time between admission to the hospital and laparotomy ranged between one and eight days. A long intestinal tube was used in five patients for decompression. Antibiotics were used in ten patients. Size of stones causing obstruction varied from 2x1 cm to 6.3x5 cm. Site of obstruction—upper jejunum in four, distal ileum in five, mid-ileum in one, sigmoid in one, and gastric outlet in one patient. The type of obstruction was intraluminal in all of our patients.

Surgical procedures included: removal of the stone, concomitant cholecystectomy, and closure of the internal biliary fistula in one patient; laparotomy and simple removal of the stone through an enterotomy incision in ten patients; and one patient, whose stone was intermittently obstructing the gastric outlet, was a prohibitive operative risk and was not subjected to operation.

The correct preoperative diagnosis was made in six patients. Hospitalization ranged from nine to twenty-one days. Early postoperative complications: wound infection in seven, paralytic ileus in two, phlebitis in one, staph enterocolitis in one, and wound evisceration in one. Late complications: incisional hernia in one, intestinal obstruction due to adhesions in one, ascending cholangitis in one (later discovered to have carcinoma of the liver). Hospital mortality: one patient died of peritonitis and pneumonia.

Discussion

Pathogenesis and Pathology—The presumed sequence in the development of internal biliary fistula is cholecystitis, pericholecystitis, adhesions, pressure necrosis, perforation, fistulization, and passage of the stone to the lumen of the gastroinestinal tract or extraluminally to the peritoneal cavity. The most common fistulas are cholecystoduodenal, cholescystocolonic, and cholecystogastric. The fistulas may extend into the jejunum, renal pelvis, uterus, portal vein, pericardium, bladder or bronchial tree.[5] On rare occasions the fistulas arise from the common bile duct.

As stones traverse the gastrointestinal tract, they tend to enlarge as they are coated with layers of bowel content. This explains gallstone ileus in patients who have had previous cholecystectomies and are without evidence of fistulization. The stones have passed through the common bile duct and enlarged during transit.[2,6,7]

The stone may migrate proximally and cause pyloric obstruction, intermittent or continuous, or be expelled by vomiting; there may be distal migration and subsequent spontaneous passage through the rectum with or without intermittent intestinal obstruction; or the patient may develop gallstone ileus. Impaction of the stone in the terminal ileum is found in 59 percent of the patients explored for gallstone ileus: upper ileum, 24 percent; jejunum, 9 percent; colon, 3-5 percent, usually sigmoid.[1,3] In the colon the obstruction may be associated with diverticulitis, adhesions, or neoplasm.

The size of the obstructing stone

Figure 8. Case 5 - Distal small bowel obstruction with pneumobilia appreciated in retrospect. Obstructing stone is non-opaque.

Figure 10. Case 7 - Mechanical small bowel obstruction with easily appreciated pneumobilia. Obstructing stone is not visible.

Figure 9. Case 6 - Large obstructing gallstone in the small bowel demonstrated with gastrographin. Pneumobilia was appreciated preoperatively.

Figure 11. Case 8 - Low mechanical small bowel obstruction due to non-opaque gallstone. Air in biliary system.

Figure 12. Case 9 - Obstructing opaque gallstone easily seen in the sigmoid colon. No pneumobilia.

Figure 14. Case 10 - Same case as Fig. 13 with air in the cholecystoduodenal fistula and barium in the right hepatic duct.

Figure 13. Case 10 - Large obstructing gallstone in the mid-ileum well outlined by barium. Air and barium also seen in biliary system.

Figure 15. Case 11 - Large gallstone in the antrum with proximal lesser curvature gastic ulcer. Both verified by gastroscopy. Barium in biliary system.

is usually between 4 and 6 cm in greatest diameter. The largest one reported in the literature measured 7.5 x 6.3 x 17.7 cm.[8]

Symptomatology—A history of previous gallbladder disease can be detected in 40-60 percent of the patients.[3] Symptoms of gallstone ileus include those related to an acute attack of cholecystitis and/or those related to the obstruction of the bowel. Almost all patients will complain of abdominal pain, distention, nausea, and vomiting. Jaundice appears if there is obstruction to the flow of bile or intraperitoneal spillage of bile. There may be obstruction with intermittent short periods of improvement when the stone obstructs, then dislodges, and keeps traversing the gastrointestinal tract.

Radiographic Findings—(1) Scout x-ray films show pneumobilia (air in the biliary tree) in 60-93 percent of the cases in different series. This may be recognized only in retrospect. Pneumobilia is suggestive of fistulization but not pathognomonic since it has been found in normal persons who have an incompetent sphincter of Oddi, in patients harboring tumors, and in patients infected with gas-forming organisms; (2) Dilated loops of bowel with air fluid leve;s (3) Visualization of the stone, if radiopaque; (4) Migration, change of position of the stone; (5) Barium studies—upper gastrointestinal series will demonstrate the site of obstruction in questionable cases. Barium may reflux into the biliary tree through the fistulous tract.

Diagnosis—The clinical picture and roentgenographic findings usually enable the surgeon to reach a preoperative diagnosis only if gallstone ileus has been considered in the differential diagnosis. Barium studies are ordered in questionable cases. Cholecystography or cholangiography will rarely demonstrate the fistula.

Treatment—Complete preoperative evaluation and preparation are mandatory since most of these patients are elderly, have associated medical diseases, and are in a state of dehydration and electrolyte imbalance.

Treatment for two to ten days with intestinal intubation in an attempt to relieve the spasm and thereby facilitate the spontaneous passage of the stone has been advocated,[1] but this is quite hazardous as more fluid and electrolyte disturbance and bowel necrosis with perforation may occur. The prime objective of therapy is to relieve the obstruction by removing the stone through an enterotomy, preferably performed with a longitudinal incision and closed transversely. The small and large bowel should be examined closely for additional gallstones, and stones of significant size should be removed.

Most surgeons have considered enterolithotomy with its resultant relief of the intestinal obstruction as adequate surgical therapy for gallstone ileus. Some surgeons have urged a secondary operation for cholecystectomy and closure of the biliary fistula to prevent recurrent symptoms of cholecystitis that have been reported in 30 percent of patients or to prevent recurrence of gallstone ileus that has been reported in 5-10 percent of patients.[3] Some authors have advocated a more aggressive approach to gallstone illeus by recommending cholecystectomy and repair of the fistula at the initial laparotomy performed for removal of the obstructing stone.[9]

It would seem logical to keep all of these options in mind when treating a patient with gallstone ileus and to individualize the decision regarding surgical management. The patient who is in relatively good health and in whom there has not been diffuse peritoneal soiling by perforation may be an excellent candidate for concomitant cholecystectomy and closure of the fistula if the inflammatory reaction in the right upper quadrant of the abdomen is mild enough to make the additional surgery technically feasible with relative safety. The patient with a gangrenous cholecystitis may require concomitant cholecystostomy at the time of enterolithotomy; and a patient whose condition is precarious or who has diffuse peritonitis or who has a marked inflammatory reaction in the right uper quadrant of the abdomen should probably be treated with enterolithotomy to overcome the acute obstruction. Plans should be made for a secondary operation for cholecystectomy and closure of the fistula in the event the patient's age and general condition warrant a secondary procedure.

The most common postoperative complication has been wound infection which was reported in as high as 50 percent of cases.[2,3] Late complications include recurrence of gallstone ileus, carcinoma of the gallbladder, recurrent attacks of cholecystitis, ascending cholangitis, severe diarrhea if the fistula enters the colon, and hemobilia secondary to erosion of the cystic artery. The mortality rate prior to 1925 was in the 30-45 percent range but, in the more recent literature, has been between 5 and 15 percent.

Summary

Twelve cases of gallstone ileus have been briefly reviewed and the x-ray findings demonstrated. During the same twelve-year period 2,183 cholecystectomies were performed, with a relative incidence of gallstone ileus of 0.5 percent. Pneumobilia was recognized preoperatively in only five patients; but, in retrospect, pneumobilia was demonstrated in ten of the twelve cases. □

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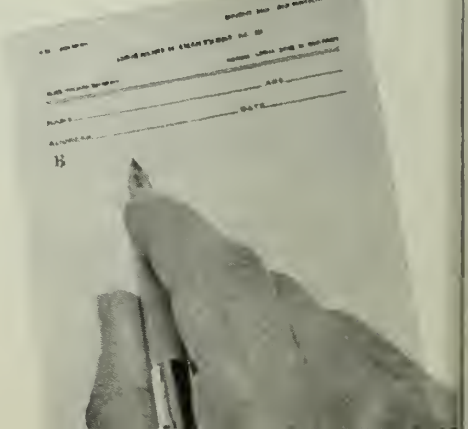
Bioequivalenc



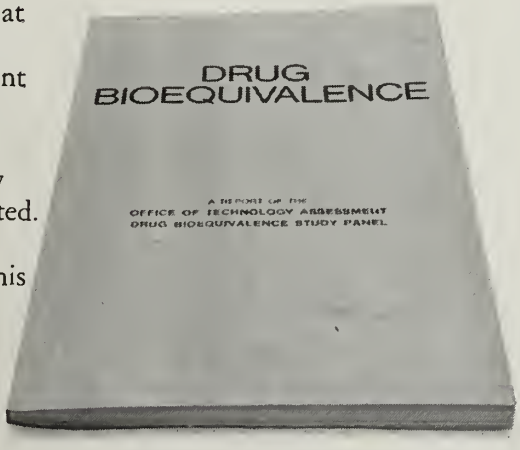
the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or

(c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A

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*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

protecting the integrity of your prescription

cardiovascular brief

Diuretic therapy in hypertension

This article was prepared for the American Heart Association, Pennsylvania Affiliate, by Arthur H. Hayes, Jr., M.D., chief, division of clinical pharmacology of Milton S. Hershey Medical Center of the Pennsylvania State University.

How Do Diuretics Exert Their Antihypertensive Action?

Chronic administration of diuretics reduces arterial pressure primarily by lowering total peripheral resistance. The mechanism responsible for this action is not well understood but may involve a direct action on arteriolar smooth muscle or alterations in the electrolyte concentrations or water content in the blood vessel walls, thereby affecting their tone or response to pressor influences. Changes in heart rate and cardiac output are not common although occasional reflex rises may be seen. Cardiovascular reflex mechanisms remain intact and orthostatic hypotension does not occur. Since diuretics promote the renal excretion of salt and water, they may cause an initial reduction in plasma and extracellular fluid. To the extent that this effect persists it may contribute to the overall antihypertensive activity of these agents. In patients with excessive fluid accumulation this action may assume relatively greater importance. A special situation exists when the level of aldosterone activity is abnormally elevated, as in primary aldosteronism, for in these patients the use of the diuretic spironolactone (Aldactone), which is an aldosterone antagonist, is more specific.

The Role of Diuretics in the Therapy of Hypertension.

The use of an appropriate diuretic should form the cornerstone of any antihypertensive drug program. Since at least ⅓ of those with mild hypertension will respond satisfactorily to the administration of a diuretic alone, such an agent should be tried first. Many with more severe or complicated forms of the disease will require additional therapy. However, all nondiuretic antihypertensive drugs cause a secondary retention of salt and water which reduces their effectiveness and therefore, a diuretic, even if insufficient alone, should be included in the total drug regimen. This will prevent most cases of "pseudoresistance" to other antihypertensive agents.

Which Diuretic Should Be Used?

In most patients with essential hypertension no significant difference in the antihypertensive efficacy of short- or long-acting benzothiazides or chlorthalidone given in adequate doses has been demonstrated. Whether the "loop" diuretics like furosemide (Lasix) have a greater antihypertensive action, remains unsettled but the greater potential for serious adverse effects argues against indiscriminate prescription. The well known greater maximum diuretic effect of furosemide does make it helpful in managing patients with otherwise uncontrollable fluid accumulation, whether primary or resulting from the use of other antihypertensive drugs. In the presence of severe impairment of renal function (creatinine clearance less than 20 ml/min.), a diuretic may not be appropriate but when indicated, furosemide should be selected since thiazides may further depress glomerular filtration rate.

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Spironolactone should probably be reserved for those with suspected or proven excessive mineralocorticoid activity or when other agents are ineffective or not tolerated. Because of its potassium sparing action, spironolactone may be combined with the thiazide or "loop" agent to prevent or minimize hypokalemia. Triamterene (Dyrenium), a potassium sparing, non-aldosterone inhibiting diuretic, although exhibiting less antihypertensive activity, may also mitigate potassium loss. Both these drugs should be used with extreme caution, if at all, in patients with depressed renal function and never with potassium supplements because of the danger of provoking serious and even fatal hyperkalemia.

Do Diuretics Cause Adverse Effects?

Fortunately chronic diuretic administration is not associated with a high incidence of serious or unpleasant side effects. However, the thiazides, chlorthalidone and furosemide can lead to hypokalemia, hyperuricemia, hyperglycemia and hypercalcemia. Hypokalemia is seldom of sufficient degree to warrant discontinuation of therapy but if serious or symptomatic may be corrected by moderate salt restriction, inclusion of potassium rich foods in the diet, potassium supplements, or the addition of a potassium sparing diuretic. The last of these is probably the most effective and best tolerated. Special attention to hypokalemia is essential in those receiving digitalis or with severe myocardial disease because of the hazard of precipitating arrhythmias.

Diuretic induced hyperuricemia when present is usually mild and requires no treatment unless it becomes marked, there is a history of gout, or frank gout develops. In these cases allopurinol or probenecid should be added to the regimen to maintain the serum uric acid level below 8 mg/100 ml. Acute attacks should be treated appropriately.

Significant hyperglycemia is uncommon even in diabetics but when it occurs is best managed by changes in diet or dosage of the hyperglycemic medication. Hypercalcemia is rare and should suggest parathyroid status evaluation. Serum determinations of potassium, uric acid, two hour post prandial glucose and calcium should be made six weeks after instituting diuretic therapy and at least twice yearly thereafter. Besides hypokalemia, spironolactone may cause gynecomastia and drowsiness, while triamterene has produced gastrointestinal irritation.

Are Diuretics in Fixed Combination Advisable?

All patients except those with severe or complicated hypertension should first be tried on a diuretic alone. If a potassium sparing diuretic is also required, optimal doses of each should be determined and then a fixed combination of the same doses substituted, if this will decrease cost and improve compliance. The same approach should be used when diuretics are combined with other antihypertensive agents.

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AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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Trends in mortality due to cirrhosis of the liver in Allegheny County — comparison with Baltimore, Maryland

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The amount of alcoholism in a population is not measurable directly. Various approaches have been used to estimate the amount, including direct personal interviews with a selected sample of the population[1] or consideration of the numbers of deaths designated as due to alcoholism or cirrhosis.[2-5] Comparison of results obtained by such various techniques have led to the conclusion that the death rate from cirrhosis might be a reliable measurement of the extent of alcoholism in a population. Though not all cirrhosis is caused by chronic alcohol abuse, the alcoholic population accounts for such a large proportion of cirrhosis that a consideration of trends in cirrhosis death rates is an excellent indication of the changing status of alcoholism in the population.[7-9]

Various studies have pointed out rising rates of deaths from cirrhosis.[10,11] In the ranking of leading causes of deaths in the United States, rates from cirrhosis have risen from thirteenth in 1950 to tenth in 1960 and ninth in 1970.[12] A previous study of cirrhosis death rates in one large urban area, Baltimore, Maryland,[13] supported the reality of this apparent increase. We have compared the rates in Allegheny County, Pennsylvania, with those in Baltimore to see whether similar trends would be observed in another area.

Methods

For Allegheny County (which includes the city of Pittsburgh) the total number of death certificates listing cirrhosis of the liver (Rubric 581, according to the 7th revision and 571 according to the 8th revision of the I.C.D.) as underlying cause of death in residents ages twenty-five to sixty-four, was summed for each race-sex age group for the years 1953 through 1972 (Table I). The population at risk in each of these years was based on the following:

(1) For the censual years and the two years before and after each census, the census population counts were used.

(2) For the other intervening years the population was intrapolated as the arithmetic average of the population at the preceding and succeeding census.

(3) For whites, annual age-specific death rates were calculated by averaging deaths over two-year intervals.

(4) For nonwhites, four years of deaths were summed and averaged to give an annual rate estimate.

(5) Baltimore rates for years 1951 through 1971 were taken from previous papers,[10 13] and more recent rates were calculated from the U.S. census data and information supplied by the Baltimore City Health Department.

All individuals who died of cirrhosis in Allegheny County in the years

TABLE I

Allegheny County, Pennsylvania Populations (1950-70)

Age	Race/ Sex	1950	1960	1970
25-44	WM	218,539	197,445	156,261
	WF	233,146	213,189	169,767
	BM	16,479	16,437	13,132
	BF	18,742	19,336	17,835
45-54	WM	82,868	92,967	95,253
	WF	84,998	98,601	106,852
	BM	8,523	7,463	13,831
	BF	7,334	7,802	15,404
55-64	WM	69,397	67,429	75,698
	WF	67,062	73,124	86,741
	BM	4,642	6,900	6,045
	BF	3,757	6,107	6,725

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TABLE II
Age Specific Death Rates Attributed to Cirrhosis (Rubric 581) 1951-1972 by Age, Race, Sex/100,000: Allegheny County, Pennsylvania

Age	Race/ Sex	1953 1954	1955 1956	1957 1958	1959 1960	1961 1962	1963 1964	1965 1966	1967 1968	1969 1970	1971 1972
25-44	WM	10	10	11	13	12	9	16	19	18	15
	WF	5	6	7	4	4	7	4	5	8	5
	BM*		3		14		16		52		67
	BF*		6		6		11		18		32
45-54	WM	42	46	55	42	54	47	56	61	61	67
	WF	16	15	30	16	18	20	26	28	32	28
	BM*		28		20		30		88		127
	BF*		26		35		33		17		54
55-64	WM	55	74	63	73	61	68	79	103	105	106
	WF	25	20	26	18	22	28	34	32	29	35
	BM*		33		43		46		64		148
	BF*		19		28		28		23		45

* Death rate calculated over a 4-year period.

1969 through 1971 were ranked by socioeconomic level as follows: For each race separately, census tracts were ranked according to median family income; the lower ranking census tracts that cumulatively contained 50 percent of that race's population were classified as "lower social class," and the higher-ranking tracts were classified as "upper social class." All individuals who died were then classified according to the census tract that had been their place of residence at the time of death. Race-specific rates of cirrhosis death by social class were then calculated.

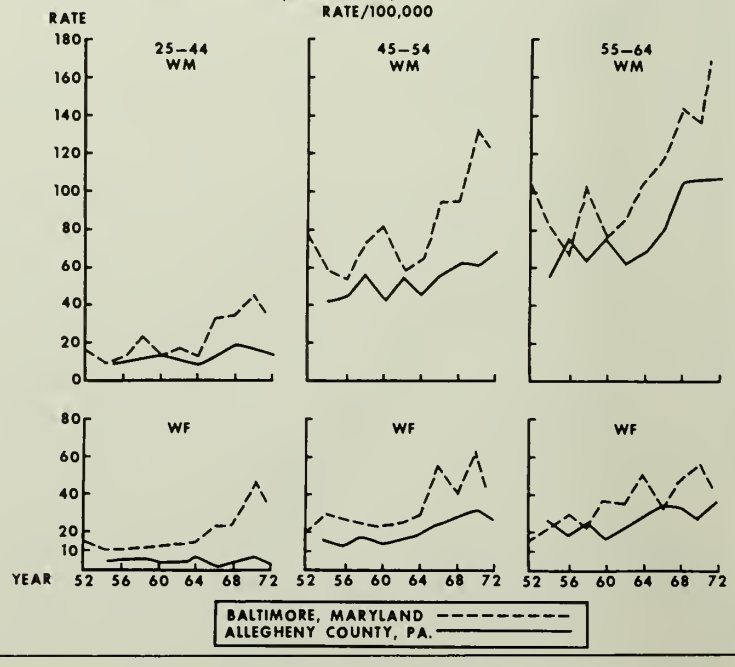
Results

Among whites in Allegheny County, several trends became apparent (Table II and Figure 1). Rates have followed an irregular pattern but have tended to increase except for females ages twenty to forty-four. In general the increase in rates had been greater in males than females. The maximum absolute change was in males ages fifty-five to sixty-four, with rates increasing from 55 per 100,000 in 1953-54 to 106 per 100,000 in 1971-72.

Changes for nonwhites have been far more striking (Table II and Figure 2). Cirrhosis death rates have risen dramatically beginning in 1964, with 1972 rates for males ages twenty-five to forty-four almost five times the 1964 rate, a nearly fourfold increase for the forty-five to fifty-four age group and almost triple rate for the fifty-five to sixty-four age group. The increase evident for nonwhite females has been much more gradual although it is still greater than observed for white females.

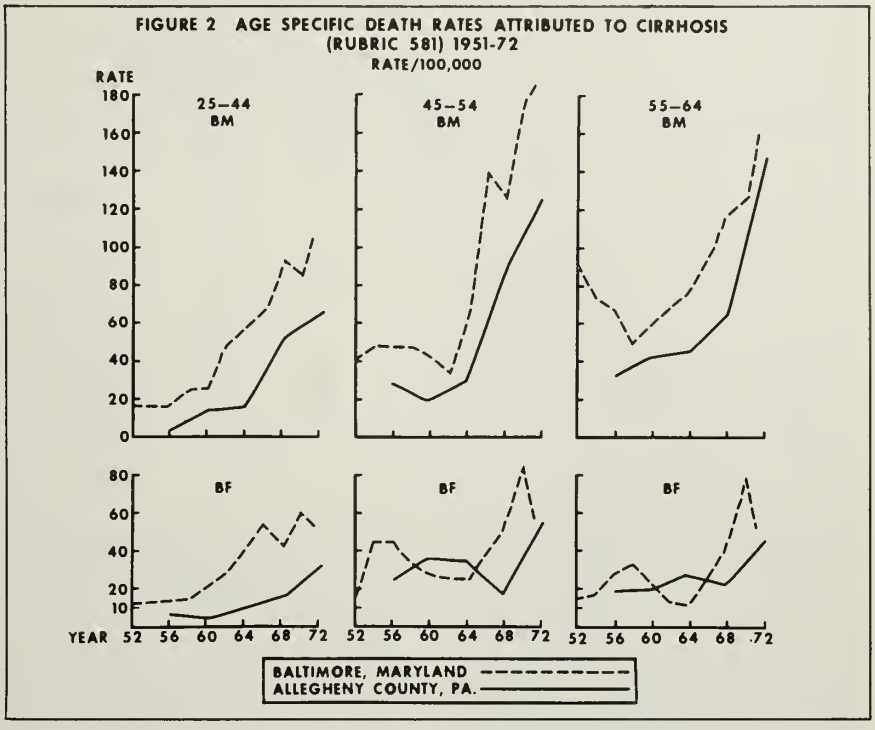
A comparison of Allegheny County cirrhosis death rates with those of Baltimore shows increases in both localities, but rates have remained consistently higher in Baltimore (Figures 1 and 2) for whites. In the entire twenty-year period for which comparison is possible from available figures, there are only two instances (males ages fifty-five to sixty-four in 1956 and females ages fifty-five to sixty-four in 1958) in which Allegheny County rates rose above those of Baltimore; and even in these two instances the differences were minimal. Furthermore, the rate of increase was greater in Baltimore. In nonwhites, on the other hand, the rate of rise has been greater in Allegheny County, the most striking change occurring among nonwhite males ages twenty-five to forty-four—from 3 per 100,000 to 67 per 100,000 in just twenty years. Even so, the rate in this group still does not match the corresponding Baltimore rates of 104 per 100,000. In fact, there were only three instances of nonwhite death rates in Allegheny

FIGURE 1 AGE SPECIFIC DEATH RATES ATTRIBUTED TO CIRRHOSIS (RUBRIC 581) 1951-72



County being higher than those in Baltimore (females forty-five to fifty-four in 1960 and 1964 and females fifty-five to sixty-four in 1964.)

The "social class" pattern for cirrhosis deaths among whites in Allegheny County in 1969-71 indicates greater rates among those of lower socioeconomic status (Table III). The number of nonwhites who died of cirrhosis was too small to allow a detailed analysis of socioeconomic ranking, but it appeared that within each age-sex group, the ratio of "lower" to "upper" was less than for whites.



Discussion

A change in the ranking of a disease among leading causes of death in the population can arise as an artifact, either due to a substantial decline in mortality from diseases previously accounting for large numbers of deaths, or to a change in diagnostic criteria. Neither of these factors can account for the rise in rank for cirrhosis during the last twenty years. It is true that two causes of death ranking above cirrhosis in 1950 (tuberculosis and nephritis-nephrosis) fell below cirrhosis in rank by 1960. However, the decline in death rates from those two causes has not been substantiated well enough to explain the increase in cirrhosis death rate on a national basis from 9.2 to 15.8 per 100,000. It is also true that advances in the study of the pathology of liver disease have improved our understanding of earlier stages of some processes leading to cirrhosis, but have not altered criteria for diagnosis of the end result. We can say with confidence that the rising position of cirrhosis in the ranks of leading causes of death in the United States is not an illusion and that the cirrhosis death rate has truly increased.

Does this increase really indicate a larger number of alcoholics in the population? Though investigators have differed on what proportion of cirrhosis deaths should be attributed to alcoholism, they have nevertheless agreed that the cirrhosis death rate is a valid reflection of the alcoholic population.[3,5,7,8] This viewpoint assumes that deaths from cirrhosis unrelated to alcohol—including primary and secondary biliary cirrhosis, post-necrotic cirrhosis, and even rare cases of classical Laennec's (portal) cirrhosis—are a relatively constant porportion of the total cirrhotic deaths. This assumption might be questioned in view of the high incidence of viral hepatitis in the armed forces beginning with the Second World War and the more recent increase in syringe-transmitted hepatitis among narcotic users. However, the sharp increases in cirrhosis death rates among females is inconsistent with the first of these objections, and the increase in older age groups (where narcotic abuse has been rare) is evidence against the second. While some minor variations in the proportion of nonalcoholic cirrhosis deaths cannot be ruled out in all of the age-sex-race groups, the marked increases in cirrhosis death rates are still valid indications of increasing alcoholism.

Although alcoholism in Allegheny County has increased impressively during the past two decades, the distinctly lower rate, compared to Baltimore, invites examination. Comparison of the two localities is

TABLE III

Distribution of Cirrhosis Deaths by Social Class
Rate/100,000 - 3 Years
(1969-1971) Allegheny County, Pennsylvania

Age	Race/ Sex	Lower No.	Lower Rate	Upper No.	Upper Rate	Ratio Lower/Upper
25-44	WM	43	96	27	24	4.0
	WF	18	38	18	15	2.6
	BM	20	277	7	130	2.1
	BF	10	90	5	77	1.2
45-54	WM	96	311	72	111	2.8
	WF	43	116	43	61	1.9
	BM	19	446	6	199	2.2
	BF	9	172	0	—	—
55-64	WM	135	486	94	199	2.4
	WF	36	110	40	75	1.5
	BM	16	436	6	288	1.5
	BF	4	85	4	186	0.4

of interest, even though no clear explanation for the difference in amount of alcoholism is apparent.

Population Composition—In Baltimore the white population has been declining substantially over the past twenty years, while the black population has been increasing. In Allegheny County (Table I) on the other hand, the white population has decreased in the twenty-five to forty-four age group but has increased in the older age groups, indicating that younger white people have been leaving but older ones have stayed. The black population of Allegheny County has shown little numerical change since 1950. These overall figures tend to indicate a greater stability of the population of Allegheny County, which includes sizable suburban areas and even a small rural population, as compared to Baltimore which is wholly urban. The significance of these differences in the Lower Allegheny County cirrhosis death rate is uncertain, but it is clear that whatever differences existed between the populations of the two localities did not prevent a rapid rise in alcoholism here.

Economic Status—On the basis of median family income distribution, in 1960 the whites in Baltimore and in Allegheny County had similar percentages of their respective populations in various income brackets, but in 1970 the Allegheny County whites occupied relatively higher income levels as compared with Baltimore. Allegheny County nonwhites, on the other hand, were poorer than those in Baltimore according to both 1960 and 1970 figures.[14,15] The higher cirrhosis death rates among lower socioeconomic levels has already been pointed out.

Method of Sale of Alcoholic Beverages—Pennsylvania is a "monopoly" state with essentially no competitive free enterprise in the sale of alcoholic beverages. Beer is sold by closely regulated private distributors, but all other alcoholic beverages (except for small amounts of "sacramental" wines) are sold in bottle amounts at state-owned stores only at uniform prices. Hours of sale at the State Stores are limited, but there is actually no effort to limit amounts sold to any individual. Alcoholic beverages are available by the glass in many establishments, but with hours of sale strictly regulated.[16] In contrast, in Baltimore liquor can be sold by many different enterprises—not only privately owned liquor stores, but even corner grocery stores and conveniently located supermarkets, etc. There is competitive pricing, and promotion and hours of sale (though state-regulated) are far less restrictive than in Pennsylvania.[17]

These two patterns of sale of alcoholic beverages reflect historic variations in public attitudes toward alcohol in the United States. In colonial days drinking at home and at mealtimes was the norm. The first temperance movement was aimed at regulating *excessive* use of alcohol, but the later American temperance movement maintained that *all* alcohol was evil.[18] The climactic achievement of this American temperance movement, total prohibition, did in fact indicate that elimination of legal alcohol consumption can result in a marked decline in cirrhosis deaths. The effects of less drastic regulation have not been so clear, however. In Finland, when beer was made easier to obtain, more people drank and many drank more.[19] It is possible that, given a certain minimum supply, those who drink manage to get as much as they want, so that people who are prone to alcoholism develop the disease and its complications. Once the availability of alcohol to a population is at a certain level, a change that makes alcohol even easier to obtain may have no effect on the prevalence of abuse and perhaps not even on the total consumption by that population.

On the other hand, it might be that cirrhosis death rates would be lowered by more stringent regulation of alcohol sales, either by means of higher tax rates or by greater restriction in the places and hours of sale.[21–23] In Pennsylvania a change from state-owned liquor stores to private enterprise has become a matter of public debate recently.

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APPENDIX TABLE I

Number of Cirrhosis Deaths (Rubric 581) 1953-54 - 1971-72, by Age, Race, Sex and Year in Allegheny County.

Age	Race/ Sex	1953 1954	1955 1956	1957 1958	1959 1960	1961 1962	1963 1964	1965 1966	1967 1968	1969 1970	1971 1972
25-44	WM	43	42	46	51	47	33	55	62	57	46
	WF	23	29	31	19	17	27	23	22	26	16
	BM*		2		9		10		29		35
	BF*		5		5		8		13		23
45-54	WM	74	82	100	79	100	88	105	116	116	128
	WF	29	28	38	31	36	40	54	59	69	59
	BM*		9		6		9		26		37
	BF		8		11		11		6		19
55-64	WM	76	101	85	98	84	97	115	153	159	160
	WF	35	28	38	26	33	44	56	53	50	60
	BM*		8		12		12		16		35
	BF*		4		5		7		6		12

* Number of deaths cover 4-year period.

present system, however, possible health consequences of such a change should be assessed. The data presented here show how difficult such prediction is. The increasing rates of cirrhosis deaths mean that there is no stable baseline for future comparison. The marked differences between Baltimore and Allegheny County show that it may not be possible to compare different localities. The duration of heavy drinking required to lead to death from cirrhosis (estimated at seventeen years)[24] means that ill effects may not be realized for a long time. Any change in the present distribution system in Pennsylvania, therefore, should be made only as part of a controlled study of its influence on alcohol consumption. First, data should be obtained for various parts of the state, and then changes should be made in selected areas with matched control localities remaining unchanged. Ongoing comparisons of sales should then be made with particular attention paid to the under thirty age groups. Such monitoring would allow ready assessment of the likely health effects, if any, of the "free-enterprise" system.

Summary

Using cirrhosis death rates as a measurement of alcoholism, the 1953-62 experience in Allegheny County has been examined according to age-sex-race and socioeconomic groups and compared with the same two decades in Baltimore, Maryland. Allegheny County cirrhosis death rates almost doubled among whites and have increased as much as fourfold among blacks. Cirrhosis death rates in Allegheny County have tended to remain below those in Baltimore, even though the rates in black males have increased more rapidly in Allegheny County. Possible explanations for the differences in rates between the two localities may be related to differences in population composition, stability, and economic status. The two localities also differ in the system of alcohol beverage sale. Any change in the method of alcohol sale in Pennsylvania should take account of trends shown in the data of this study and consideration should be given to a long-term controlled study of the possible effect of such changes on the increasing cirrhosis death rates. □

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Inhalation injury in burned patients

SMOKE inhalation greatly increases the morbidity of the patient with thermal injuries. "Pulmonary burn" is a misnomer, for rarely is the injury to the respiratory tract caused by direct heat.[1] True pulmonary burns follow the inhalation of live steam or the explosion of an anesthetic gas mixture within an intubated patient. More commonly, the inhalation of the toxic by-products found in smoke cause a chemical laryngotracheobronchitis or produce asphyxia due to carbon monoxide poisoning.

Inhalation injury associated with burns may be divided into three clinical stages: respiratory insufficiency, pulmonary edema, and pneumonitis.[2] Unless death supervenes, all untreated patients will develop most of the signs and symptoms in each of these stages.

The first stage usually begins within a short time of the exposure and lasts for 24-36 hours. It is characterized by ventilatory insufficiency due to obstruction of the tracheobrochial tree by a chemical mucositis and edema, hemorrhage and edema into the pulmonary parenchyma and loss of alveolar capillary membrane intregrity.[2]

The second stage, pulmonary edema, does not begin until 6-8 hours after the burn and lasts for several days. It is characterized by increasing intra-alveolar edema, and ventilatory insufficiency. Chest roentgenograms reveal patchy pulmonary infiltrates without the vascular engorgement which is usually associated with pulmonary edema.

The final stage is pneumonitis, which develops as the edema laden pulmonary parenchyma is colonized by microorganisms 3-4 days following the burn. This pneumonia is bilateral, multifocal, virulent, and frequently lethal. The early organisms are bacterial, but with the use of large doses of antibiotics to treat burn wound sepsis, or septicemia, an increased incidence of secondary pulmonary invasion by viruses and fungi results.

TABLE I

Early Signs and Symptoms of Inhalation Injury

Symptoms	Signs
	1. Constricting edema or escher of face and neck
1. "Patient overcome by smoke"	2. Singed nasal vibrissae
2. Irrational behavior	3. Soot stained oral or nasal mucosa
3. Dyspnea	4. Carbonaceous sputum
4. Change in voice or hoarseness	5. Tachypnea
5. Cough	6. Arterial PO_2 is low

The paucity of clinical signs and symptoms makes the initial diagnosis of inhalation injury difficult.[3] The physician responsible for evaluating burned patients must maintain a high index of suspicion and search for the early diagnostic clues of pulmonary injury in attempting to alter the lethal progression of this condition. Patients with the obvious signs and symptoms of inhalation injury such as cyanosis, wheezing, hypoxemia, rales, and roentgenographic evidence of pulmonary edema within a few hours after inhalation injury are unlikely to survive.[4]

Clues suggesting possible inhalation injury include burns caused by explosion or those which occurred within a closed space. Was the patient "overcome by smoke?" Did he exhibit irrational behavior, or develop a cough or hoarseness following the exposure to smoke? The physician should note upon examination whether: (1) the burn involves the head, neck, and chest areas; (2) there is a constricting eschar developing about the neck or chest; (3) the nasal vibrissae are singed; (4) there is sooty staining of the oral or nasal mucosa; and (5) the patient is coughing or hoarse. Dyspnea, tachypnea, irrational behavior, cyanosis, or the cherry red color of carbon monoxide poisoning are the other important signs. (Table I) Examination of the chest should be carefully performed, recorded, and frequently repeated to detect the appearance of wheezes, rales, and rhonchi.

Laboratory studies which are useful and practical in confirming the diagnosis of inhalation injury are the chest roentgenogram, arterial blood gases, and determination of carboxyhemoglobin levels. Probably the earliest and most sensitive indicator of ventilatory insufficiency is hypoxemia, which is best measured by serial blood gases determinations. Before any roentgenographic changes occur, the PO_2 and ph levels decrease while the pCO_2 levels rise. Measurement of arterial blood gases is also a useful parameter in evaluating the response to treatment of the patient with an inhalation injury.

Although the first chest roentgenogram may be entirely normal, 8-12 hours later early evidence of pulmonary edema and atelectosis usually develops.[2,3] Serial roentgenograms are performed to follow the patient's course. Carboxyhemoglobin levels greater than 30 percent are potentially serious

The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services cooperate in the dissemination of information on trauma. This paper was prepared by the department of surgery of the Milton S. Hershey Medical Center.

and require subsequent periodic measurements. Levels greater than 60 percent are life threatening for carbon monoxide has an affinity for the hemoglobin molecule which is 200 times greater than oxygen, thus reducing the oxygen carrying capacity of the blood.[4]

Therapy of inhalation injuries requires maintaining a satisfactory airway, reducing laryngotracheobronchial edema and inspissated secretions, increasing the arterial PO_2, preventing the progression of pulmonary edema and treatment of pneumonia. (Table II) Early tracheostomy was at one time recommended for virtually all burns involving the face and neck to assure an airway prior to the development of edema in these areas. This philosophy is no longer tenable because endotracheal intubation is regarded as safe and less likely to contribute to ulcerations of the tracheobronchial tree with the development of bronchopneumonia.[5] Soft endotracheal tubes may be easily kept in place for the duration of maximum airway edema, 36-72 hours. On the other hand, if a respirator is required, if the patient is unable to tolerate intubation or it is necessary to maintain the endotracheal tube for more than three or four days, then a tracheostomy should be performed in an elective and unhurried fashion. Both the endotracheal and tracheostomy tubes require meticulous care to keep the airway patent and avoid the introduction of microorganisms which may produce pneumonia.

Preventing inspissated secretions is aided by providing supplemental oxygen that has been maximally humidified. Chest percussion and postural drainage as well as encouraging the patient to cough up his secretions are important routines. Bronchodilators such as aminophyllin and broncholytic agents such as parenteral sodium iodide or supersaturated potassium iodide are also helpful adjuncts in liquifying tracheobronchial secretions. Edema of the laryngotracheobronchial mucosa may be quite severe justifying the administration of large physiologic amounts of corticosteroids, 20-25 mg/kg (hydrocortisone succinate) or comparable doses of another steroid given every 6-8 hours during the first 36 hours. The dangers of corticosteroids in possibly contributing to the development of a Curling's ulcer as well as enhancing the risk of infection, is appreciated; however, in severe inhalation injury their limited use is justified.

TABLE II
Therapeutic Guidelines for Inhalation Injuries

1. Maintain satisfactory airway
   a. Endotracheal intubation
   b. Tracheostomy—occasionally
2. Decrease laryngotracheobronchial edema and mucositis
   a. Bronchial dilators—aminophylline
   b. Corticosteroids—20-25 mg/kg hydrocortisone succinate
3. Decrease and clear inspissated secretions
   a. Humidified oxygen
   b. Chest percussion and postural drainage
   c. Broncholytic agents—supersaturated potassium iodide
4. Prevent hypoxemia
   a. Supplemental oxygen via croup tent
   b. Volume respirator
5. Treat bacterial pneumonitis
   a. Based on culture and sensitivity reports of specific organisms

To prevent hypoxemia and maintain acceptable arterial PO_2 levels the patient is housed in a croup tent through which high concentrations of humidified oxygen can be delivered. Frequent monitoring of the arterial blood gases enables one to decide when the patient no longer requires the tent or conversely if the PO_2 is below 60 percent in this enriched atmosphere, guides in the decision to provide mechanical ventilatory support. Although pressure ventilators are adequate for short term use, our preference has been for volume controlled respirators in order to overcome the airway resistance secondary to the marked mucosal edema and decreased chest wall compliance. The concentration of oxygen required plus the tidal volume delivered to the patient by the respirator is based on the need to maintain an arterial PO_2 between 70 and 100 mm Hg. There is a tendency for patients on these respirators to develop hypocapnea and alkalosis unless dead space or 5 percent CO_2 is added to maintain the pCO_2 at about 35 mm Hg. Periodic sampling of the patient's blood gases is used to determine when to wean the patient from the respirator. Although mechanical respiratory support is of great benefit, it also carries the risk of causing a pneumothorax, or forcing microorganisms into the lungs which may lead to pneumonia.

While pulmonary edema associated with inhalation injuries is unaccompanied by vascular engorgement, treatment of thermal injury requires massive amounts of fluid which can cause a previously healthy heart to fail. Fluid administration is monitored carefully with the central venous pressure recordings. In major burns in all patients, elderly patients with burns, or those patients with possible associated inhalation injury, the pulmonary capillary wedge pressure rather than the central venous pressure is a more accurate reflection of the ability of the left side of the heart to handle fluid loads. The usual range of normal for the pulmonary capillary wedge pressure is between 5 and 20 cm H_2O. Other useful adjuncts in treating pulmonary edema are the judicious use of digitalis with careful monitoring of the serum potassium, diuretics and assisted ventilation.

Finally, every attempt must be made to decrease the likelihood of virulent bacterial, viral or fungal contamination of the inevitable chemical pneumonitis which develops in these patients. All of the therapeutic modalities thus far mentioned are helpful but most patients will develop a bacterial pneu-

monia. Prophylactic antibiotics are of little benefit in preventing this and may actually be harmful by causing the emergence of resistant strains of bacteria of a superinfection by a virus or fungus. The patient's sputum or a tracheal aspirate is examined and cultured daily. Antibiotic therapy is based on the presence of particular organisms and their specific sensitivities.

Summary

Smoke inhalation injuries are frequently difficult to diagnose due to few early signs and symptoms. A high index of suspicion must be maintained and early and vigorous therapy begun in order to reverse an otherwise lethal injury. □

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Cutaneous sporotrichosis—a case report

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Sporotrichosis is an indolent, predominently cutaneous infection uncommonly found in clinical practice. The initial lesion of localized inflammation can easily be assumed to be a bacterial infection and often only after various antibiotics have failed is a fungal etiology considered. We report a case originating in Pennsylvania which was originally unrecognized and treated as cellulitis.

Case report

In early November 1973, a forty-four-year-old white male sustained minor blunt trauma to his left elbow. Several days later he noted redness and swelling of a 2x2 cm area on the left forearm just proximal to the wrist, thought to be due to a welding spark burn. At that time the patient was begun on oral penicillin. There was slight clinical improvement in response to the antibiotics, but two weeks later it was found that a tender mass had developed above the left elbow. There was no history of fever or chills and the patient denied alcoholism, drug intake, or other systemic diseases; his temperature was normal. A 2 cm erythematous area on the dorsum of the left forearm with a 0.5 cm central necrotic area (Figure 1) and a large, tender, epitrochlear node was present. Elbow range of motion was from 30 to 105 degrees with limitation of pronation and supination possibly secondary to an old injury. The white blood cell count was 3,600, hematocrit and erythrocyte sedimentation rate was normal. A roentgenogram of the left elbow revealed an old, healed fracture with secondary degenerative changes. The initial impression was partially treated cellulitis, but

Figure 1. P.M. cutaneous lesion of sporotrichosis; note central necrotic area.

because of the marked lymphadenopathy, a fungal etiology was considered. Cultures were obtained from the cutaneous lesion and left elbow aspiration for routine, acid fast, and fungus, and the patient was begun on Nafcillin pending these results. Over several weeks there was no response to Nafcillin therapy. The erythematous focus on the forearm persisted and some increased enlargement and tenderness of the epitrochlear node were noted. Plans to biopsy the node were deferred when the fungus culture revealed *Sporotrichium Schenckii.* Therapy was changed to saturated solution of potassium iodide 3 grams orally every six hours with progressive improvement during the next twelve weeks. At that time the skin was healed and the epitrochlear node had regressed. Treatment was continued for one month beyond total clearing of the lesions.

This paper was prepared jointly by the Division of Orthopaedic Surgery, Department of Surgery, and the Division of Infectious Disease, Department of Pediatrics of the Milton S. Hershey Medical Center.

Discussion

In this case, the correct diagnosis was not made on the first two attempts at treatment because sporotrichosis is uncommon in clinical

practice in Pennsylvania. The disease has a broad worldwide distribution including South Africa where in one epidemic 2,835 mine laborers were infected from contaminated mine timbers.[1] In the United States the disease is endemic to the Mississippi Valley, but is rather widespread geographically. Recent reports have originated from Illinois,[2] Minnesota,[3] Michigan,[4] Virginia,[5] and Ohio.[6]

The fungus was first isolated by Schenck from a patient at the Johns Hopkins Hospital in 1896. This was identified by F.F. Smith as sporotrichium and has been called *Sporotrichium Schenckii* since 1900. The fungus is not often seen in animal tissue, but the spores exist in soil, moss and thorny plants. Domestic animals, birds and insects may act as passive carriers. A scratch from a rose thorn is a classical inoculating mechanism. Culture of the organism provides the most direct and reliable means of establishing a diagnosis. The organism will grow on Sabouraud glucose medium or Mycosel at room temperature. Complement fixation, agglutination and cutaneous hypersensitivity tests are available, but provide only supportive evidence of infection.[7]

The natural history of cutaneous sporotrichosis closely follows the pattern of the case described here. Initially an insignificant scratch develops into a pustule, papule, or nodule enlarging to a diameter of 2-5 cm. Lymphatic spread is then seen with the development of a chain of subcutaneous nodules which may ulcerate and drain a thin grey to yellow discharge. Regional lymph nodes often enlarge. The disease may invade locally to involve a contiguous joint or tendon sheath.[6] Unifocal pulmonary, articular, and bony sporotrichosis occurs.[2] Disseminated disease, i.e. multifocal systemic sporotrichosis, can be fatal. Though rare, when seen it is often found in debilitated patients such as alcoholics, or those with cancer, diabetes or other systemic diseases.[4] This emphasizes the opportunistic nature of this infection. Asymptomatic sporotrichosis may be seen just as in histoplasmosis and coccidiomycosis.

Differential diagnosis for cutaneous sporotrichosis includes cellulitis, bacterial pyoderma, tularemia, and other fungi. Sporotrichosis synovitis must be differentiated from destructive rheumatoid arthritis, pigmented villonodular synovitis, tertiary syphilis, trauma and other causes of chronic monoarticular arthritis. Disseminated sporotrichosis must be distinguished from tuberculosis, staphylococcal osteomyelitis, malignancy and other systemic fungal infections.

Cutaneous and lymphatic sporotrichosis can be reliably treated by the oral administration of a saturated solution of potassium iodide (1 g per ml) in the date of 2-3 ml four times daily. This should be continued for one or two months beyond apparent healing. In our patient, this provided satisfactory results. Griseofulvin has been used in cutaneous disease with both success and failure reported. For diseminated sporotrichosis, Amphotericin B has been successful in eradicating the disease while iodides are generally ineffective.[4] Renal toxicity with elevation of blood urea nitrogen and creatinine often limit therapy.

When response to antifungal agents is unsatisfactory, surgery may be indicated to remove disease foci. Debridement of joints, synovectomy, resection of bone and occasionally arthrodesis[2,3,6] all may bring substantial pain relief and enhance medical therapy in sporotrichosis of bones and joints. Lobectomy has been used in conjunction with iodides and Amphotericin B for unifocal pulmonary sporotrichosis.

Summary

A case of cutaneous sporotrichosis occurring in Pennsylvania is reported with particular emphasis on fungal cultures as an aid to diagnosis. The disease is uncommon and can easily be mistaken for bacterial infection. Treatment with iodides is satisfactory for the cutaneous form of the disease, but Amphotericin B and perhaps surgery is indicated for disseminated sporotrichosis, which is rarer and considerably more difficult to treat.□

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obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Henry Paul Bauer,** Miami, Fla.; Jefferson Medical College, 1927; age 72; died January 3, 1975. He was chief surgeon at Spencer Hospital, associate surgeon at Meadville City Hospital, and a member of the American College of Surgeons. He is survived by his wife, two sons, one of whom is H. Paul Bauer, Jr., M.D., a sister, and a brother.

• **Martin O. Blechschmidt,** Cressona; University of Leipzig, 1919; age 83; died January 15, 1975. Surviving are his widow and a son.

• **Raymond F. Campbell,** Norristown; Medico-Chirurgical College of Philadelphia, 1915; age 88; died January 24, 1975. He was a member of the State and Montgomery County Medical Societies, the American Medical Association, and the Philadelphia Radiology Society. His wife, a son, and five daughters survive him.

• **William E. Connelly,** Williamstown; Hahnemann Medical College, 1933; age 72; died January 19, 1975. He was a member of the American Medical Association and the American Academy of Family Physicians. He is survived by his wife, a daughter, and three brothers.

• **Otis M. Eves,** Berwick; Temple University School of Medicine, 1938; age 66; died December 23, 1974. He was a fellow of the American Academy of Family Physicians and an instructor for the Pennsylvania Heart Association. His widow and three daughters survive him.

• **Morris Ginsburg,** Philadelphia; University of Pennsylvania School of Medicine, 1909; age 87; died February 2, 1975. In 1959 Dr. Ginsburg was honored by the State Society for 50 years of medical service. In 1963, in honor of his 75th birthday, the University of Pennsylvania School of Medicine established the Dr. Morris Ginsburg Prize for students who demonstrate special dedication and "other significant qualities of the ideal physician." His widow, a son, two daughters, two brothers, and a sister survive him.

• **Harland DeV. Hotham, Jr.,** Freeport; University of Pittsburgh School of Medicine, 1931; age 69; died January 17, 1975. He was a member of the American Academy of Family Physicians. He is survived by his wife, a son, two daughters, and a sister.

• **Auleene Marley Jamison,** Cortland, Ill.; University of Pittsburgh School of Medicine, 1918; age 85; died January 14, 1975. She is survived by two daughters.

• **Charles Shinji Kambe,** Philadelphia; University of Pennsylvania School of Medicine, 1943; age 59; died February 2, 1975. He was deputy director of surgery at Episcopal Hospital and associate professor of surgery at Temple University Medical School. He was certified by the American Board of Surgery and appointed a fellow of the American College of Surgeons. His wife, two sons, one of whom is Joseph C. Kambe, M.D., a daughter, two brothers, and a sister survive him.

• **Turney L. Kirkwood,** Kittanning; University of Pittsburgh School of Medicine, 1934; age 67; died January 28, 1975. He was a member of the American Academy of Family Practitioners and on the board of directors of Butler and Armstrong County Heart Associations. Surviving are his wife, a daughter, and two brothers.

• **John J. McCague, Jr.,** Pittsburgh; University of Pittsburgh School of Medicine, 1953; age 46; died February 2, 1975. He was vice president of the Western Pennsylvania Society of Anesthesiology, a fellow of the American Society of Anesthesiologists, and a diplomate of the American Society of Anesthesiology. Surviving are his wife, four sons, and three daughters.

• **Charles J. Morosini,** Scranton; Jefferson Medical College, 1925; age 76; died January 22, 1975. He had practiced medicine in Scranton 49 years. He is survived by his widow, a son, Charles J. Morosini, Jr., M.D., and three sisters.

• **Howard Myers,** Philadelphia; Medico-Chirurgical College of Philadelphia, 1911; age 84; died November 30, 1974. Information regarding survivors is unavailable.

• **Wilhelm Renold Schillhammer,** East Montpelier, Vt.; University of Vermont College of Medicine, 1923; age 78; died November 21, 1974. Information regarding survivors is not available.

• **S. Neitz Seibert,** Reading; Jefferson Medical College, 1969; age 50; died January 24, 1975. He is survived by his wife.

Clarence T. Hemmings, Erie; Western Reserve University Medical School, 1912; age 86; died December 29, 1974. He was a fellow of the American College of Surgeons, a diplomate of the Board of Obstetrics and Gynecology, and a member of the American College of Obstetrics and Gynecology. His widow and a son survive him.

James D. Kelly, Philadelphia; George Washington University, 1961; age 39; died February 1, 1975. He was a diplomate of the American Board of Radiology and vice president of Pennsylvanians for Human Life. Surviving are his wife, six sons, two daughters, and his mother.

James Edward McDowell, Narberth; Jefferson Medical College, 1910; age 87; died January 5, 1975. He was a fellow of the American College of Surgeons and a member of the American Urological Board. A sister survives him.

Thomas P. McWilliams, Phoenix, Arizona; Duke University School of Medicine, 1948; age 51; died January 3, 1975. He was a diplomate of the American Board of Internal Medicine and past president of the Lackawanna County Heart Association. His widow, three sons, three daughters, and a sister survive him.

have made it virtually impossible for insurance companies to predict the expenses of the program, to intelligently underwrite the costs and to define appropriate premiums.

As the risk becomes less insurable, companies who engaged in the business over the years are trying to get out of it as rapidly as possible. This has created a major crisis over the country and specifically so here in Pennsylvania. In the present climate of freely given awards, it is readily understandable that doctors are afraid to practice without insurance to cover alleged instances of malpractice. And yet, in this state and in other states, the malpractice insurance coverage is being withdrawn by the insurance carriers. In Pennsylvania, the Pennsylvania Medical Society has an agreement with the Argonaut Insurance Company of California to the effect that they will cover every member of our Society who applies and who is judged insurable until June of 1979. But despite that contract, they have stated that they will no longer insure any physician in Pennsylvania after the 31st of December, 1975. There are 4,000 doctors in Pennsylvania insured with this company who will be without coverage at that time. No other company which currently writes malpractice insurance in Pennsylvania is willing to pick up any additional customers whether they come from another previously insured program, whether they are new physicians trying to come into Pennsylvania, or whether they are recently trained physicians just graduating from medical school and wishing to start practice in Pennsylvania.

On February 28, the Pennsylvania Medical Society instituted suit against Argonaut Insurance Company of Menlo Park, California. We did this to prevent a health care catastrophe in Pennsylvania. With no other insurance company clearly willing to pick up these 4,000 doctors, most of them will be forced to stop practicing. Overnight, the state may well lose 22% of its doctors, affecting more than 2.6 million Pennsylvanians. That is the crisis we face.

Although I speak for the 13,000 members of the Pennsylvania Medical Society, I am not alone in voicing alarm over this malpractice insurance crisis. May I quote, Commissioner, from your statement of February 5, "If doctors can't get the insurance coverage they need, they are understandably afraid to practice medicine and our whole health delivery system would be thrown into chaos and confusion."

The malpractice insurance problem is not unique to Pennsylvania. In nearby Maryland, St. Paul Fire and Marine Insurance Company has asked to leave the state. To date, the insurance commissioner and the courts have said no. Four thousand doctors are affected.

In Michigan, the three carriers that do practically all the state's malpractice underwriting are pulling out June 30. Already they have stopped accepting new policyholders—thus preventing any new doctors from moving to Michigan. Some of these doctors would like to come to Pennsylvania but can't get insurance here either.

In New York State, Argonaut nearly doubled the rate when it moved in and then less than a year later asked for a 196% rate increase. Subsequently they determined to leave New York State as of July 1. This affects more than 20,000 physicians.

In Illinois the number of claims filed under the Medical Society's program has doubled in the last six months . . . the insurance company has had to increase its reserves to handle anticipated claims by 400%.

In California malpractice insurance premiums have jumped 600% over the past ten years. In one Long Beach community hospital, the annual malpractice premium has jumped in ten years from $12,000 in 1969 to $820,000 this year. The cost per patient day for this insurance has skyrocketed from 10 cents a day to $3.65 a day.

One national insurance company scheduled to testify at these hearings has said that it has seen the number of claims pending against the doctors it insures more than double since 1969. In a five-year period the ratio of doctors with claims against them has gone from 1

in 23 to 1 in 10.

I have described some of the national dimensions of the problem, but what are its effects here in Pennsylvania? What would Argonaut's departure mean to Pennsylvanians? I asked our members this question and here is what they said. I am going to read to you brief excerpts from a few of the nearly one hundred letters which I received. Here is how the malpractice crisis is affecting Pennsylvanians:

A group of pediatricians writes, "Our office serves approximately 15,000 families. We would have to close if we cannot obtain insurance. There are five doctors with some 150 man-years of experience in our practice ... we cannot practice without insurance."

A general surgeon from Mifflin County writes: "It is a frightening thought, but many of us in this small community feel that there is no way that we can continue to practice without insurance coverage. Few of us are in the financial position that we could turn our backs with security; most of us are dedicated to our profession and sincerely enjoy our work, but are unwilling to put ourselves in the position where a person's assets would be the only means of settling a lost case. Many of us find the alternatives to practicing medicine devastating."

A general practitioner from Erie County writes: "Personally, should I not be able to acquire malpractice insurance, the community of _____ would be without a doctor after having one for twenty years, i.e., me. I cannot afford to practice medicine without malpractice insurance and, if it is not available, I just know that I, along with hundreds of other doctors, will no longer subject ourselves to public annihilation financially."

An internist from Pittsburgh wrote the following to me by hand so as not to alarm his office employees: "There is no question whatsoever that I will quit practice should it become impossible to have malpractice insurance. Although I am only age 50 I will manage somehow to maintain an existence. I currently see on the average 300 patients per week in the office not to mention the hospital calls."

Later in these hearings we shall support a rate increase for Argonaut necessary to keep them in business. But we view rate increases as a temporary stop-gap measure. The real solutions must come in the Legislature. Legislative remedy is necessary because the present insurance apparatus has failed. It is outmoded. It cannot cope with a medical technology which has an obsolescence turnover every ten years. Under the present horse and buggy malpractice insurance arrangement:

1. Fear of suit is causing physicians to practice "defensive medicine." They are taking more X-rays, running more lab procedures, getting more consultations than their own medical judgment dictates. They do this to protect themselves. They fear being sued. The result is that patients are subjected to unnecessary, sometimes painful and even dangerous tests. Meanwhile, employers and employees pay higher health insurance premiums to cover these costs. Listen to what a doctor from the western part of the state writes: "Defensive medicine is the order of the day for everybody, including practitioners working here for more than fifty years."

Another doctor from the center of the state writes: "One of the problems that we see now is the large number of laboratory studies and X-rays that are being performed only because we are afraid of malpractice suits."

2. Some physicians are backing away from performing high-risk procedures. This is particularly true of neurosurgeons. In Flint, Michigan, brain surgeons have refused to perform certain procedures out of fear of possible suit.
3. Older doctors are being hassled: the result is that they are preparing for early retirement. Here is what they are saying: "My malpractice insurance has just gone from $1,140 to $1,700 for next year. I feel if it goes much higher I will have to drop services to the public. I

am 64 and have some years to practice yet but if necessary I shall stop, and then the community and hospital will be harder pressed, as I am the main Eye, Ear, Nose and Throat staff member."

A general practitioner writes:

"I see no way that I can continue in the practice of medicine if I have to raise my fee schedule to cope with the rise of malpractice insurance. My patients are country folks and cannot afford a rise in fees. The medical profession is already being criticized for the excessive costs. I am presently 65 and take care of an active GP practice and my patients will suffer if I leave."

The rising cost of malpractice insurance impacts on the young physician as well as the old. Listen to the words of a Professor of Obstetrics and Gynecology from Pittsburgh:

"We now have two residents in our program who plan to enter practice in July of this year. Both have been offered an association with well established, highly reputable and competent physicians in the western Pennsylvania area. Neither of these residents has been able to obtain malpractice insurance, either on their own or from the current provider of their prospective associates. They have been unable to obtain insurance at any price. Both of these fine physicians are now seriously considering establishing practice out of the state of Pennsylvania."

Society's desire to provide compensation for medical disabilities is driving the present malpractice insurance system bankrupt. Malpractice insurance is being misused to provide patient compensation. Malpractice premiums paid by doctors are being used to finance disability benefits, health insurance benefits, life insurance type benefits for patients. What has developed is an inefficient patient compensation apparatus, grown up like topsy, which returns on the average only 16 cents of each premium dollar to patients. The rest of the malpractice insurance dollar goes into administration and legal expenses. Compare this with Pennsylvania Blue Shield which returns approximately 90% to the patient.

The next aspect I should like to discuss with you is who is responsible for the present situation and indeed the one responsible is just about everyone in this room. We start as we did with my first remarks with society and its wish to provide a social welfare program for a segment of the population but without accounting for the costs or the means of meeting these costs. The real travesty of the cost situation in the present approach is that society is asking the sick patient to pay from his pocket for the care that society would give to other sick patients. This is a far cry from a broad based support program such as workmen's compensation with which this system is and should be analogous. The sick patient, whether he is visiting a doctor in his office or in the hospital, cannot afford to pay the amounts of money now demanded by the present system. Related to the generous philosophy of society is also the expectancy of society. Medicine is a most successful profession. Miraculous deeds can indeed now be accomplished. The life expectancy of the American citizen and the health conditions under which he lives have never been better. But despite this, the result of the very inate abilities in medicine to cure diseases has resulted in the expectancy that every condition can be completely cured and return to a normal state of life completely assured. One sees this every day on television with the iron that makes women forever young and with the aspirin that goes higher and higher and higher to relieve every complaint. The very effectiveness of the medical profession itself in its daily practice further enhances this expectation.

And then there is responsible also our court system which expands principles which are basically reasonable to an unreasonable extent. There is, for example, a concept of informed consent. It is indeed quite reasonable that a patient should in general have some idea of what his disease means, and what the means of coping with that disease are. But to require as do the courts at present that every aspect of the patient's disease and his management be explained to him in full detail with all of the hazards involved, leads only to a demand for the practice of bad medicine. The art of medicine is extremely important in promoting the welfare and well-being of the patient. And part of this art is the assessment of the patient and what the doctor, at that time—not on Monday afterwards—but at the time, judges to be the most consistent path to his diagnosis and correct treatment. We must return to the reasonable man approach and not expect that every health provider should sit down and explain to every patient the possible complications of having a simple soapsuds enema.

The concept that promises to cure are inherent in encouragement of the patient to undergo treatment must be eradicated. No good physician will guarantee the result of his mangement nor can he do so and the implication that such a contract or guarantee exists can be sustained only when given in writing.

The permission of the discovery of insurance and the amount of coverages made known to lawyers, has encouraged the demands for ever greater awards.

There is also the contingency fee permitting plaintiffs' lawyers to retain 50% or more of a judgment, contributing in no small part to the intolerable fact that only 16 cents out of every malpractice insurance dollar goes to the patient whereas 84 cents out of every dollar goes to legal and administrative costs. Society would not tolerate this in any other form of insurance.

You will hear it said that the malpractice system is the only means of disciplining the medical profession. There is no more false statement that has ever been made on this subject. There are no known data showing that lawyers on winning malpractice cases turn around and give their evidence to have physicians removed from practice. Indeed, quite the reverse is correct because it is to the advantage of the

practicing lawyer to keep the physician in practice who does indeed engage in negligent practice for therein lies the source of income for that lawyer.

Today, the Pennsylvania Medical Society makes the same bold move that it did 36 years ago when it established Blue Shield, and it now calls for legislative action on the malpractice scene. We believe a law is needed which will protect the legal rights of all patients; police the medical profession to weed out incompetents, and place patient compensation on a sound financial base. To accomplish these objectives, we support a bill called the "Pennsylvania Medical Malpractice Reform and Patient Compensation Act." It was introduced today in the House of Representatives.

The principal provisions of the Malpractice Reform and Patient Compensation Act are threefold:

1. First, it creates a Patient Compensation Board, appointed by the Governor and confirmed by the Senate. The Board is composed of two lawyers, two doctors and two laymen. This Patient Compensation Board divides into two three-man hearing boards. The lawyers, consumers and doctors appointed to the Patient Compensation Board are fulltime; they may have no other source of income. Their job is to hear complaints from patients, whether the patient can afford a lawyer or not. Cases are heard promptly. Little cases as well as big cases, not just those that appeal to juries. And the awards from the Board . . . the patient compensation money, all of it, goes to the patient. His attorney is paid a fee determined by the Board.
2. If the Board finds that the injury was caused by "willful or wanton misconduct" on the part of the doctor, in addition to awarding money to the patient, the Compensation Board must turn the case over to the medical licensing board for disciplinary action.
3. Finally, so that we can stop bad doctors from practicing medicine, the bill gives back to the medical board the money it collects in licenses so that it can hire investigators and attorneys to enforce the disciplinary provisions in the new Medical Practice Act, which the Pennsylvania Medical Society succeeded in getting through the Legislature last year.

There are additional details in the bill. I am submitting to you, Commissioner, for the record, a copy of the bill as well as a summary and analysis. Incidentally, we have received word that a similar bill just passed the Indiana House by a vote of 81 to 16 out of a possible 100 votes.

In conclusion, Commissioner, I see that you will hear from a number of doctors, laymen, and insurance experts in these hearings. I suspect that the picture which will emerge is one composed of the following elements:

1. The cost of medical care being increased as the skyrocketing malpractice insurance premiums are passed on to patients, employees and employers.
2. The cost of medical care rising as doctors increasingly practice defensive medicine.
3. Pennsylvania health care suffering as a result of older doctors retiring from practice early, because they cannot spread the high cost of premiums over their limited practice.
4. Pennsylvania health care suffering as a result of young doctors going to other states because they either cannot get insurance in Pennsylvania or cannot afford it.
5. There is the prospect of Pennsylvania losing 22 percent of its doctors who care for some 2.6 million Pennsylvanians.
6. There is the prospect of patients seeking compensation through a system that returns to them only 16 cents on the dollar.

In short, the picture which I believe will emerge is one of an archaic discredited and financially ailing insurance system incapable of dealing with the risks of today's medical technology.

During the time that these problems have been developing in Pennsylvania:

Government has had to step into the area of work accidents through workmen's compensation laws;

Government has had to step in with a no-fault law to bring back order to the automobile insurance industry.

What is the cure? The cure is not insurance. Ever increasing insurance premiums simply increase the cost of medical care and perpetuate a system with inequitable distribution of awards for medical disability and an inordinately small return to the patient. The cure lies in appropriate legislative changes along the lines which we have been recommending and which will (1) establish a patient compensation commission, (2) modify the definition of informed consent, (3) restrict the statute of limitations, (4) eliminate promises to cure except when in writing, (5) prohibit the disclosure of the amounts of insurance, (6) require that witnesses in cases be competent in the field under discussion, (7) require that counter claims be admitted to prevent nuisance suits, and (8) specifically, that the Board of Medical Education and Licensure be given the staff and funds that permit them to investigate and to properly deal with the physician who is indeed guilty of medical malpractice. Such they do not have at the moment and it is this absence of authority in the hands of those who can best judge their peers that has permitted the few incompetents to remain on the active practice scene.

On behalf of the Pennsylvania Medical Society I wish to commend you for holding these hearings. You are providing a valuable service to the citizens of the Commonwealth. We thank you for the opportunity to testify. We hope that our testimony and that of others will help you take the necessary actions to protect the people of Pennsylvania. And we are confident that you will endorse the recommendations we have made and add the prestige and weight of your office in working to bring about these necessary changes.

Dr. Crane explains suit at press conference

A. Reynolds Crane, M. D., Society president, answered reporter's questions and explained the Society's law suit against Argonaut Insurance Co. at a press conference in Philadelphia at the time the suit was filed (for details see page 7). Below are excerpts from the question and answer session with reporters.

Are the doctors so bad that they cannot practice without malpractice insurance?

The doctors are not bad, it's the system that is bad. The doctors are good. But if everything that happens as a result of medical disease is laid at the fault of the doctor, regardless of facts, the doctor cannot prejudice his family, his holdings, his whole financial existence on the whims of juries, courts, and what segments of the legal profession would do.

Are you saying then, sir, that courts and juries and so on are unfairly operating against doctors at this time?

This is not a doctor-public matter, this is a matter of society's health. What is happening is that we are attempting to underwrite a medical disability program with a malpractice dollar and that is morally, ethically, and financially wrong. Because you are trying to underwrite a medical disability program with money taken from the pocket of the person who can least afford it, the man who is sick. If we are going to have broad insurance coverage which will take care of the illnesses and the results of illnesses of all the population, then society as a whole has to do this.

Doctor, what is it that you want from the Legislature?

Well, right now our concern today is with, of course, the courts and our immediate concern is with the Argonaut Insurance Company to see that we have insurance beyond the end of this year so that doctors will not be encouraged to discontinue their practice and so that new doctors can come into the state and start in practice. This is our immediate concern.

You did mention, however, legislation . . .

Yes, for the long term project, we need a complete change in the court system and the manner in which claims of negligence are assessed and in which judgments are distributed.

In the broad sense, what are you looking for from the Legislature? When you say change in the court system, what do you mean?

I mean complete revision of the system of assessing claims . . . coping with such things as the contingency fee, statute of limitations, and many other aspects which encourage the continuation of an unrealistic system.

Doctor, you mentioned that the contract is being terminated. When does the contract actually run out?

We have an agreement with Argonaut for five years, and it would go to 1979. It's been renewed every year for an additional five years ahead. It was renewed last year for another five years.

So it doesn't expire until 1979?

Correct, that is correct. May of 1979.

How much does it cost a physician to have malpractice insurance?

It varies. The cost is highest in the big cities, lowest in rural areas. In Philadelphia the range goes from approximately $300 to $5,000 a year. With the projected increase for which the Argonaut Insurance Company has asked 207 percent, these fees will be up in the $10,000 to $15,000 range. It varies, of course, with specialty area. It's high in those specialties that have the most dramatic exposure in the surgical fields, for instance, and less in the areas dealing with general practice and the less dramatic, but nonetheless vital, areas of medicine.

Is the insurance company giving you an option to pay more for the insurance coverage and if you won't pay more, then you'll be dropped? Is that what it is, it's not . . .

No, this would be helpful if it were. No, the position at this point is that the insurance company is asking for a rate increase of 207 percent, but regardless of this, their present position is that they will cease writing malpractice insurance on December 31 of this year whether they get the increase or not. Their continuation has to this point not been contingent upon their receiving increased fees.

Could you characterize for me, I'm still hung up a bit about the legislative activity you want. How do you characterize it? Is it meant to benefit the doctor and in what way?

No, it's not meant to benefit the doctor. It's meant tc benefit the patient. That's what this is all about. It's meant to enable the doctor to cope with the rendering of medical care without interference. One real problem, for instance, which is particularly bad in Pennsylvania is a matter of informed consent. The state courts of Pennsylvania have interpreted a doctrine of informed consent to mean that unless a doctor explains every detail of every procedure to a patient, he has not properly informed the patient and is liable for suit. The result of this is that if you did indeed attempt to explain in detail everything that might happen to everyone, you would be practicing bad medicine because you would certainly completely destroy his acceptance of the necessity of the care and the gambles of it. This makes the practice totally unreal and impractical. A doctor does something which in his judgment is normal, good, accepted procedure, and the patient is not satisfied with the result, so the doctor is open to suit. Related to this, of course, is the concept that society expects perfection. We cannot deliver perfection, and when the public does not get perfection every time, then they want compensation for it in as much a dollar total as they can get.

What is the Pennsylvania Medical Society's position on those doctors? There are some cases of malpractice, I assume that's the Society's position. What's its position on the patients' rights in that type of circumstance?

I think the most important thing where actual malpractice exists is to get that physician penalized in addition to putting money in a patient's pocket. But the most important thing to society is to see that he does not go on and do this same thing to another patient. So our position with the man who is engaged in practice and who does indeed willfully and negligently treat a patient should be dealt with strongly by the State Board of Medical Education and Licensure in an appropriate fashion.

What about the patient's problem. The patient could obviously be blinded, unable to work, doesn't someone have a responsibility to the patient?

Yes, indeed. But what society has to do is decide how much it can afford and how to make a system which provides justice for any patient who has a legitimate claim. If there is indeed a matter that the patient has a disability for which he should be compensated, this must be done by a system of fairness to all claimants. It would be manifestly unfair for one man to come off with several million dollars while Mr. Smith, with the same problem, gets nothing. That's the horror of the present system and society has just got to face the problem of getting equitable treatment for malpractice cases. We've got to take care of the patient as well and as fairly as we possibly can in terms of restitution; and also we've got to get the incompetent doctor out of the way. We're not doing either very effectively at the present time.

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pennsylvania medicine

May 1975

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Jonathan E. Rhoads, M.D.
Distinguished Service Award Nominee
Pennsylvania Medical Society

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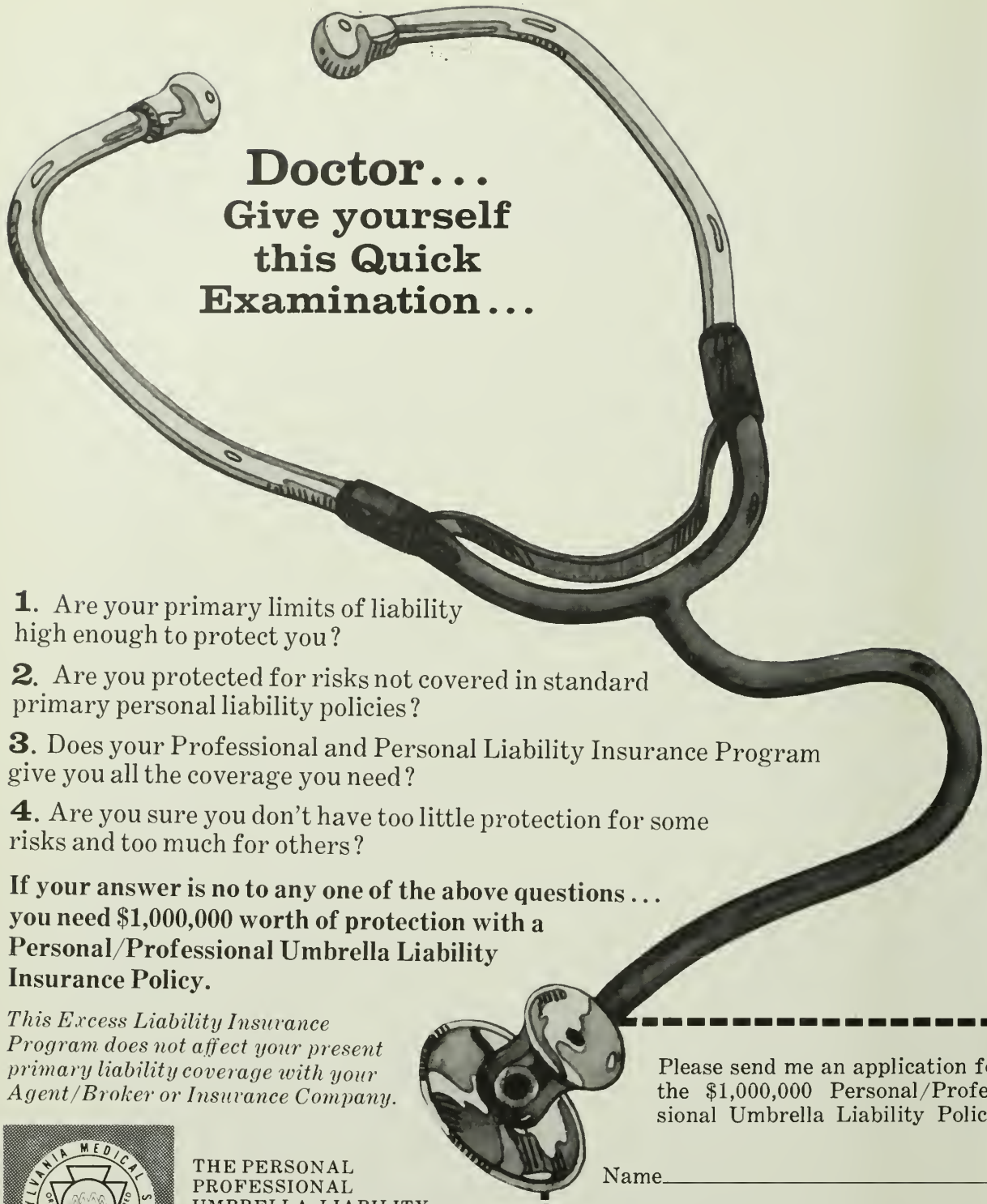
Handling medicare refund claims—page 34



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PMS V. ARGONAUT SETTLED The suit of the Pennsylvania Medical Society against Argonaut Insurance Co. was settled April 25 with a stipulation approved by Judge Stanley M. Greenberg of the Philadelphia Court of Common Pleas. According to the arrangement, Argonaut will honor its contract with the Society to write malpractice insurance for all qualified Society members until May 31, 1979. The agreement was reached following an announcement by Insurance Commissioner William J. Sheppard April 22 that Argonaut's request for a 206.9 percent premium increase had been granted. Although he approved $2.2 million of the requested rate increase, Commissioner Sheppard denied Argonaut's request that it be applied retroactively to current policies. He thus cut off $4.8 million from a request for what would have been a $7 million increase for 1975. The April 22 increase of 206.9 percent will be applied only as current policies come up for renewal. In the court case settlement, the court retains jurisdiction if questions should arise. In the matter of the premium increase the Society has insisted that the increase be validated by claims experience, and reserves the right to call for premium adjustments if experience shows the new rate to be excessive. While Argonaut may elect to limit policies to $200,000/$600,000, if a member formerly carried higher limits, or by the nature of his practice requires higher limits and is unable to purchase umbrella insurance, Argonaut must provide or obtain the higher limits. The table below shows old and new rates for basic coverage. Surcharges applicable to individual situations (suits, incorporation, foreign medical graduates) are not shown.

PHILADELPHIA

	OLD			NEW		
Class	Basic*	Increased Limit**	Total	Basic*	Increased Limit**	Total
1	196	89	285	602	412	1,014
2	344	146	460	1,056	712	1,768
3	743	342	1,085	2,280	1,734	4,014
4	1,886	845	2,731	5,788	4,124	9,912
5	2,911	1,296	4,207	8,934	6,358	15,292

REMAINDER OF STATE

	OLD			NEW		
Class	Basic*	Increased Limit**	Total	Basic*	Increased Limit**	Total
1	161	76	237	494	341	835
2	284	123	407	872	591	1,463
3	596	277	873	1,829	1,314	3,143
4	1,188	538	1,726	3,646	2,604	6,250
5	1,485	668	2,153	4,557	3,250	7,807

* Basic Coverage - $25,000 each claim/$75,000 aggregate limit.
** Increased Limits - $200,000 each claim/$600,000 aggregate limit.

CO-OP BOARD ELECTS OFFICERS The Incorporating Board of the Pennsylvania Medical Cooperative elected the following officers at its first meeting April 19: H. Robert Davis, M.D., Boiling Springs, president; Robert N. Moyers, M.D., Meadville, vice president; Robert Poole, M.D., West Chester, secretary; John F. Rineman, Society executive vice president, treasurer; and Richard L. Huber, M.D., Scranton, assistant secretary treasurer. The first annual meeting of the cooperative membership will be scheduled within 90 days of the board meeting, and articles of incorporation are scheduled for publication in the July issue of PENNSYLVANIA MEDICINE. A drawing for prizes for which all charter members were eligible was held April 23 during the Society's Officers' Conference. First prize --a trip to the British Isles and Holland--was awarded to Jorge A. Querimit, M.D., of Williamsport. A complete list of prize winners will appear in the June issue of this publication.

RUSH AWARD WINNERS ANNOUNCED Cyrus B. Slease, M.D., chairman of the Society's Board of Trustees, has announced recipients of the Benjamin Rush Awards--the Society's highest honor to laymen for health service. The awardees, who will be honored at the state dinner during the Annual Session of the House of Delegates, are Roger A. Congdon, Sr., of Ulster (Bradford County), for his activity in providing delivery of emergency medical services; and the Susquehanna University Student Volunteer Program, which involves as many as one-third of the 1400 students in a variety of volunteer activities.

ELLIOT KNAUER, DR. STEIGERWALT DEBATE HSAs Among those who spoke at the Society's highly successful Officers' Conference April 23-24 were Elliot R. Knauer, director, Division of Comprehensive Health Planning, Pennsylvania Department of Health, and John L. Steigerwalt, M.D., of Rosemont, chairman of the Society's Commission on Health Planning. Knauer defended the department's recommendation of seven Health Service Areas to be established under P.L. 93-641, the Health Planning and Resources Act. Dr. Steigerwalt explained the Society's recommendation that HSA boundaries generally follow previously established PSRO boundaries. Governor Milton J. Shapp will make his recommendation for the boundaries to the U.S. Department of Health, Education, and Welfare early in May. HEW has the final say on area boundaries.

AMA HEALTH INSURANCE BILL INTRODUCED The Comprehensive Health Care Insurance Act, the AMA's proposal for national health insurance, was introduced in the U.S. House of Representatives April 22 with bipartisan support. The bill is considered the only substantially new approach to national health insurance introduced to date in the Ninety-fourth Congress. It builds on the existing structure of employer-employee group health insurance plans and provides federal assistance on the basis of need. Catastrophic coverage is a key feature of the bill.

pennsylvania medicine

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MAY 1975 VOLUME 78, NUMBER 5

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PENNSYLVANIA MEDICINE, established in 1897, is published monthly as the official publication of the Pennsylvania Medical Society. All original papers and correspondence should be directed to the Managing Editor. Subscription requests and changes of address should be sent to PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043. A subscription is $5.00 per year. Single issues are 50 cents. Second class postage is paid at Lemoyne, Pennsylvania 17043.

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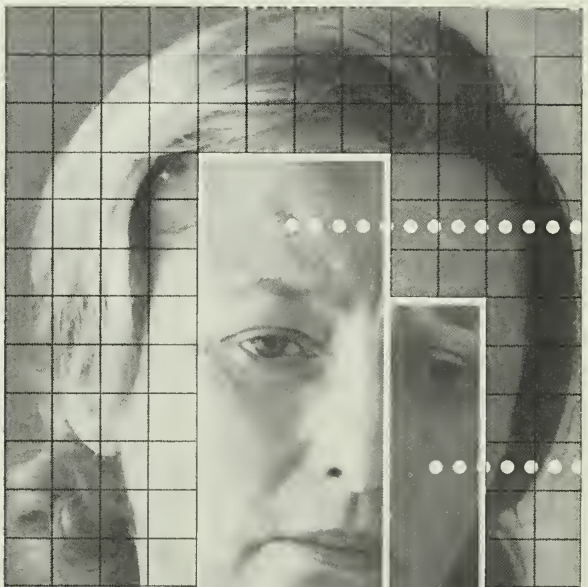

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in freque and/or severity of grand mal seizures require increased dosage of standard a convulsant medication; abrupt withdra may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous gestion of alcohol and other CNS depre sants. Withdrawal symptoms (similar t those with barbiturates and alcohol) h occurred following abrupt discontinua (convulsions, tremor, abdominal and r cle cramps, vomiting and sweating). K addiction-prone individuals under care

respond to one

According to her major
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is is because her problem,
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excessive anxiety is re-
ed, the depressive symp-
is associated with it are also
n relieved.

There are other advan-
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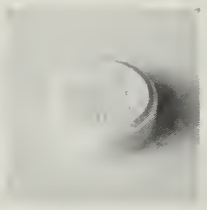
ium is pronounced and
id. This means that im-
vement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

eillance because of their predisposi-
to habituation and dependence. In
nancy, lactation or women of child-
ing age, weigh potential benefit
nst possible hazard.

autions: If combined with other psy-
ropics or anticonvulsants, consider
fully pharmacology of agents em-
ed; drugs such as phenothiazines,
otics, barbiturates, MAO inhibitors
other antidepressants may potentiate
tion. Usual precautions indicated in
nts severely depressed, or with latent
ession, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
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cardiovascular brief

MAY

Is National High Blood Pressure Month

The Pennsylvania Affiliate of the American Heart Association, its Chapters, the State Department of Health, the American Red Cross, and the Pennsylvania Medical Society are cooperating with federal and national organizations in a nationwide promotion this month to help make the public more aware of the dangers of high blood pressure and the importance of having blood pressure checked regularly as a preventive measure. The following materials are available from the Heart Association for physicians or for physicians to give to their patients. For a sample copy or information about an item, please check the list below and send to the Pennsylvania Heart Affiliate. To order quantities of these materials, please contact your local heart association.

ITEMS FOR PHYSICIANS

- ☐ Hypertension: Office Evaluation (Booklet)
- ☐ Hypertension: Drug Treatment (Booklet)
- ☐ Recommendations for Human Blood Pressure Determination by Sphygmanometer (Booklet)
- ☐ Outline of Recommended Antihypertensive Regimens (Desk Card)
- ☐ Reports of Inter-Society Commission for Heart Disease Resources:
  - ☐ Primary Prevention of Hypertension
  - ☐ Resources for the Management of Emergencies in Hypertension
- ☐ Drugs Used in the Treatment of Hypertension (Reprint)
- ☐ Criteria for Evaluation of Automated Blood Pressure Measuring Devices for Use in Hypertensive Screening Programs (Reprint)
- ☐ Information about Modern Pharmacological Management of Systemic Hypertension (slide-cassette set)
- ☐ Coronary Risk Handbook: Estimating Risk of Coronary Heart Disease in Daily Practice (Booklet)
- ☐ Stroke Risk Handbook: Estimating Risk of Stroke in Daily Practice. (Booklet)

ITEMS FOR PATIENTS AND PHYSICIANS' OFFICES

- ☐ High Blood Pressure (Booklet)
- ☐ How Can High Blood Pressure Hurt You? (Booklet)
- ☐ High Blood Pressure and How To Control It (Booklet)
- ☐ How You Can Help Your Doctor Treat Your High Blood Pressure (Booklet-available on physician prescription)
- ☐ Your High Blood Pressure Prevention Card (Leaflet)
- ☐ Sodium Restricted Diets (Booklets-available on physician prescription)
  - ☐ Mild Restriction
  - ☐ 1000 Milligrams
  - ☐ 500 Milligrams
- ☐ Perform a Death-defying Act, Have Your Blood Pressure Checked (Poster)
- ☐ High Blood Pressure (Posters-set of two)

For sample copy or information about these materials, check this form and send to:
AMERICAN HEART ASSOCIATION, PENNSYLVANIA AFFILIATE
P.O. Box 2435, Harrisburg, Pennsylvania 17105

NAME (Please Print) _____

ADDRESS _____ ZIP _____

president's page

'Challenge now before us'

The first phase of our effort to provide protection for ourselves and our patients against the emerging malpractice calamity which threatens to destroy the orderly delivery of health care in the Commonwealth is now completed. The most difficult challenge is now before us.

In the last four weeks—a period of intense activity—more than 800 of us and our wives met together in this common cause. On March 18, legislative activity was initiated in the House of Representatives and on that same day the Insurance Department's hearings opened in Philadelphia. Many parties offered testimony. I presented the Society's position on the opening day of the hearings. That testimony appears in full in the April issue of PENNSYLVANIA MEDICINE. On the third day of the hearings, spokesmen for Argonaut Insurance Co., while pleading for a rate increase, reversed their previously announced intention of withdrawing from Pennsylvania at the end of 1975—a switch which is a direct result of our suit to force the company to abide by its five year arrangement with the Society.

As you know, on March 18, the Society caused to have introduced in the State Legislature House Bill 805, the Pennsylvania Medical Malpractice Reform and Patient Compensation Act. An initial informal hearing was conducted by the House Judiciary Committee on April 9. The Society was represented at the hearing by legal counsel,

Dr. Crane testifies at Insurance Department Hearings. Other photographs of the hearings are on page 14.

Fred Speaker, Society legal counsel answers questions of the House Judiciary Committee.

myself, and staff. We are providing answers to the committee on a number of questions regarding physician manpower and malpractice claims and settlements.

A special meeting was held April 22 with officers of various organizations with an interest in and concern about the malpractice problem. Among those represented were the state associations for dentists, nurses, podiatrists, attorneys, hospitals, and others. The purpose of the meeting was to acquaint these groups with the contents of H.B. 805 and to enlist their support. The reaction was a general recognition of the urgency of the problem and a willingness to cooperate.

You have a copy of the April issue of PENNSYLVANIA MEDICINE. I urge you to keep it at hand. It contains an exact reproduction of House Bill 805, the background as contained in the testimony presented to the Insurance Commissioner, and an update on Society activities to that time. Use it as a reference as you explain the problem and the Society's proposed solutions to your patients, neighbors, and friends, and particularly to members of the State Legislature.

If you need the names of your legislators, call us on the Hot Line—(800) 932-0645. PaMPAC has prepared a directory of all Pennsylvania legislators which will be sent to you. We have sent you copies of the patient pamphlet. More are available. Your county society has a copy of a speech for use with lay audiences. Newspaper advertisements are being prepared.

We have had a successful beginning—but it is just the beginning. Now the groundswell of membership participation must begin. Informed physicians imparting the knowledge in an objective way to the public is the next orderly step in our campaign to prevent the calamity which threatens every citizen of the Commonwealth.

A. Reynolds Crane, M.D.
President

Jonathan Rhoads named for distinguished service award

Jonathan Evans Rhoads, M.D., of Philadelphia, has been named a recipient of the Distinguished Service Award of the Pennsylvania Medical Society by the Board of Trustees. The board acted on a recommendation of its Committee on Distinguished Service Award which reported the candidate "more than qualified for the award in either the category of meritorious service in the science and art of medicine or whose public life and activities have been of such outstanding nature as to reflect clearly great credit on the profession." The gold medal will be presented at the Society's House of Delegates meeting in October.

Dr. Rhoads becomes the sixth recipient of the award, which was presented for the first time in 1956 to Jonas E. Salk, M.D., formerly of Pittsburgh and now director of the Salk Institute in California, for his successful research on a vaccine for poliomyelitis. In 1962, John H. Gibbon, M.D., of Philadelphia, who pioneered in the field on open heart surgery and perfected the heart-lung machine, was honored. James Z. Appel, M.D., of Lancaster, received the award in 1967 in recognition of outstanding leadership in organized medicine. The medal was presented in 1970 to Eugene P. Pendergrass, M.D., of Wynnewood, director emeritus of radiology and radiation therapy at the Hospital of the University of Pennsylvania, for his many national and international contributions in this field. Russell B. Roth, M.D., of Erie, immediate past president of the AMA, was presented the award last year in recognition of his statesmanship as a leader of organized medicine.

Jonathan Rhoads was born in Philadelphia, received most of his education in the Philadelphia area, and has spent his professional life there.

Born May 9, 1907, Dr. Rhoads attended Germantown Friends School, Westtown School, and Haverford College, where he earned his B.A. degree. He received his medical degree at Johns Hopkins University School of Medicine in 1932 and served his internship and residency at the Hospital of the University of Pennsylvania, where he later became an instructor in surgery. In 1940 he was certified by the American Board of Surgery and received a Doctor of Science degree at the University of Pennsylvania Graduate School of Medicine.

Honorary degrees include Doctor of Science from Haverford College, Swarthmore College, and The Medical College of Pennsylvania, and Doctor of Laws from the University of Pennsylvania.

Dr. Rhoads has been active in various medically related organizations, the National Research Council, United States Public Health Service, and Veterans Administration among them. He served as vice president of the American Cancer Society in 1968-1969, was president the following year, and has served on several of its committees.

Professional affiliations are numerous. Dr. Rhoads has served as president and chairman of the board of regents of the American College of Surgeons, chairman and a member of the executive council of the Association of American Medical Colleges, president of the College of Physicians of Philadelphia, and president and director of the American Trauma Society.

Currently Dr. Rhoads is professor of surgery at the University of Pennsylvania School of Medicine and on the surgical staff of the Hospital of the University of Pennsylvania. He is surgical consultant at Germantown Dispensary and Hospital, Philadelphia, Children's Hospital of Philadelphia, Monmouth Medical Center, Long Branch, New Jersey, Veterans Administration Hospital, Philadelphia, Bryn Mawr Hospital, Bryn Mawr, and Pennsylvania Hospital, Philadelphia.

He served as provost of the University of Pennsylvania from 1956 to 1959, as director of the Harrison Department of Surgical Research there from 1959 to 1972, and as John Rhea Barton professor of surgery at the institution to which he devoted much of his professional life from 1959 to 1972.

He and his wife, Teresa Folin Rhoads, live in Philadelphia. They have six children: Margaret Rhoads Kendon, Jonathan E., Jr., George G., Edward O. F., Charles J., and Philip G.

Dr. Rhoads serves as a delegate to the State Society's House of Delegates and has served the State Society and the Philadelphia County Medical Society in numerous ways during his career. The Distinguished Service Award will be presented at the state dinner during the House of Delegates Annual Session at the Host Farm Inn, Lancaster, October 7.

American Blood Commission inaugurated at convention

The American Blood Commission (ABC) was officially established at the recent two-day inaugural convention held in Washington, D.C. The commission was formed by delegates from 46 organizations concerned with achieving a safe and adequate blood supply for the United States.

The commission will be concerned with leading the way for nongovernmental agencies to collaborate in achieving goals of improved supply, quality, accessibility, and efficiency stated in the National Blood Policy announced by Secretary of Health, Education and Welfare Caspar W. Weinberger in July 1973. Goals include eliminating the duplication of blood donor recruitment, improving performance of blood banks throughout the country, minimizing blood wastage, and expanding voluntary donation to increase safety of patients requiring blood.

Officers and the board of directors were elected at the convention. The president is John J. Corson, who had served as chairman of the Ad Hoc Committee to Establish the ABC. The vice presidents are Frederic S. Laise, senior vice president of the American National Red Cross, and Louis M. Aledort, M.D., medical director of the National Hemophilia Foundation. Klaus Mayer, M.D., immediate past president of the American Association of Blood Banks, is secretary treasurer.

A number of organizations participated in establishing the ABC. Among them were the American Medical Association, American Cancer Society, American Association of Blood Banks, American College of Surgeons, American Heart Association, American Hospital Association, American Society of Clinical Pathologists, National Kidney Foundation, and the Pharmaceutical Manufacturers Association.

County Society has home

The Lancaster City and County Medical Society recently acquired a central office in the Medical Bureau Building, 139 East Walnut Street, Lancaster.

It is the first time in over 30 years that the society has had a home base. In the past it has relied on the local hospitals and schools to provide locations for meetings.

Psychiatric society installs Dr. Hostetter

Abram Martin Hostetter, M.D., was installed as president of the Pennsylvania Psychiatric Society, representing approximately 1,000 psychiatrists, at the society's annual meeting held at the Sheraton-Valley Forge Hotel, April 11-13.

Other officers elected during the Society's three day meeting were: Morton Johan, M.D., Pittsburgh, president elect; Richard A. Crandall, M.D., Harrisburg, secretary treasurer; Robert E. Jones, M.D., Philadelphia, I. Floyd Mallot, M.D., Pittsburgh, Edward C. Leonard, Jr., M.D., Philadelphia, Norman L. Loux, M.D., Sellersville, councilors; and Joseph M. McGrath, M.D., Harrisburg, auditor.

DR. HOSTETTER

Dr. Hostetter has held numerous appointments in the Harrisburg, Hershey and Lebanon County area, including those of consulting psychiatrist for the Lebanon County Public School System, the Family and Children Service of Harrisburg, the Dauphin County Child Care Service, and the Hershey Hospital. He also served as medical director of the Philhaven Hospital during the period 1969-71 and was assistant professor of psychiatry at the Pennsylvania State University, 1971-72.

Present appointments include those of consulting psychiatrist at Harrisburg Polyclinic Hospital, Lancaster-Lebanon Intermediate School Unit, and Good Samaritan Hospital, Lebanon. He is medical director of the Lebanon Family and Children's Service.

Dr. Hostetter holds professional memberships in numerous societies and associations including the American Psychiatric Association, the American Orthopsychiatric Association, the Lebanon County and Pennsylvania Medical Societies, and the American Medical Association.

He and his wife, Patricia Ann, and their four children live in Annville. He maintains a private practice of psychiatry in Hershey. Dr. Hostetter received his Bachelor of Arts Degree from Goshen College, Indiana, in 1953 and his Medical Degree from Jefferson Medical College, Philadelphia, in 1957. He served his internship at Methodist Episcopal Hospital, Philadelphia, and his residency in psychiatry at Norristown State Hospital.

County society accredited for Category One

The State Society's Commission on Accreditation has granted provisional accreditation to the Lackawanna County Medical Society for a newly developing continuing education program. The program is being developed under the direction of the Lackawanna County Medical Society's Continuing Medical Education Committee, of which Randall W. Snyder, Jr., M.D., is chairman. Accreditation is for one year and the program is subject to critical review at the end of that period.

Elizabethtown hospital has new direction

New legislation redefining the role of the Elizabethtown Hospital for Children and Youth has made possible expanding services while keeping costs at a minimum for patients and taxpayers.

Act 286 broadens the function of the Elizabethtown Hospital for Children and Youth, formerly the State Hospital for Crippled Children, from primarily an inpatient institution for indigent children to a hospital and center providing ambulatory and inpatient services for those under 21 with many types of physical or neurodevelopmental disabilities. Robert W. Saunderson, Jr., M.D., is medical director of the facility.

The hospital has broadened its services to include comprehensive diagnosis, treatment, and rehabilitation of complex disabilities. The staff has expanded and includes specialists in orthopedic surgery, urology, general pediatrics, pediatric neurology and neurosurgery. Physical therapists, social workers, specialists in construction and use of orthopedic appliances, and teachers have been added to the staff.

The new legislation will permit the hospital to collect payments from a patient's family according to ability to pay by using the standard state plan for family participation.

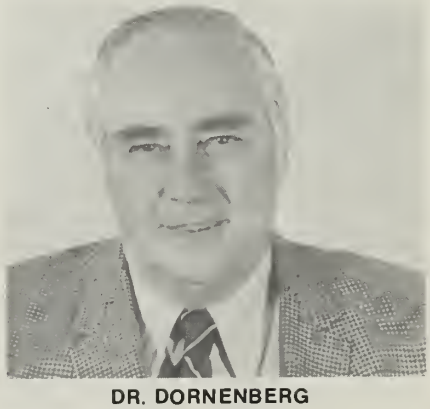
Blue Shield elects new board members

Four physicians recently were elected to three-year terms on the Board of Directors of Pennsylvania Blue Shield. The new board members are: James A. Collins, M.D., an internist at Geisinger Medical Center, Danville; Donald R. Cooper, M.D., Philadelphia surgeon and professor and chairman of the department of surgery at the Medical College of Pennsylvania; James R. Dornenburg, M.D., a Pittsburgh general surgeon; and Grant Underwood, M.D. a urologist from Washington.

These newly elected members replace retiring members: William F. Brennan, M.D., a Pittsburgh internist; Allen W. Cowley, M.D., a Harrisburg cardiologist; William A. Limberger, M.D., an internist in West Chester; and William T. Rice, M.D., a radiologist in Rochester.

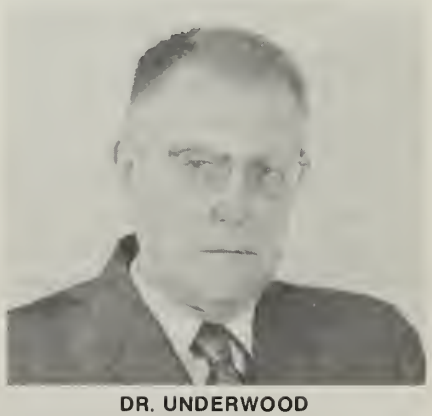
Re-elected to the Blue Shield Board of Directors are: A. Reynolds Crane, M.D., Society president and Philadelphia pathologist; John H. Harris, Jr., M.D., a Carlisle radiologist; Edmund L. Housel, M.D., Philadelphia internist; George Shuman, Jr., financial vice president and treasurer of Dickinson College, Carlisle; and Rowland G. Weber, vice president of the insurance and benefit plans, American Stores Group Services, Inc.

DR. COLLINS



DR. DORNENBERG

DR. COOPER



DR. UNDERWOOD

Eastern Pennsylvania Health Care Council—foundation

The Eastern Pennsylvania Health Care Council is in the midst of a campaign which has as its goal signing as individual members the physicians in the counties of Lehigh, Northampton, Carbon, Monroe, Wayne, and Pike—which comprise the Area IV Professional Standards Review Organization (PSRO).

The council, a foundation for medical care incorporated under Pennsylvania law as a nonprofit organization, was born last summer and has been operating with funds raised by a $50 assessment of the membership of the county medical societies in the area. Its immediate goal, according to Michael H. Ufberg, M.D., of Allentown, council president, is the establishment of three keystones on which to build quality medical care in the area. He lists them as: 1. Preventive care, 2. ambulatory care where possible, and 3. peer review, including review of ambulatory care and preadmission certification for hospital stays.

Dr. Ufberg and the other officers of the council have been carrying the message to various public groups in the area as the council attempts to involve nonphysicians in the Board of Directors and various committees. Two councils are being established. The nonphysician provider council would represent other health professionals—hospital personnel, pharmacists, home health care agencies, etc. The community council would include representatives of local government, management, labor, and third party carriers. Each of these councils would have two members on the Board of Directors.

The other 15 members of the 19-member board will be physicians representing the medical and osteopathic medical societies in the area. Although patterned after other open-panel foundations for medical care, the council is unique in its effort to involve the community and other members of the health care team at the decision-making and committee levels.

Prior to beginning its organizational efforts, the council studied the closed panel health maintenance organization concept, but "chose the open panel

A SERIES of meetings to acquaint the community with the Eastern Pennsylvania Health Care Council was conducted early in 1975. In the top photograph, Dr. Ufberg is shown speaking to a group of business officials. The second photograph is of a group of physicians and union officers who gathered at the Lehigh Valley Club to discuss the aims of the foundation. Assisting in answering questions at the meetings were Leon N. Branton, M.D., president of the Lehigh County Medical Society; David A. Tilly, M.D., president of the Area IV PSRO; David Prager, M.D., of Allentown; and other organizational representatives of the council.

Medical board has two new members

Two new members have been added to the State Board of Medical Education and Licensure in accordance with Acts 189 and 190, which require a member from allied health sciences and one from the public. The members are: Nathan Hershey, Esq., allied health sciences, Forty-third Senatorial District; and Barbara K. Shore, public member, Thirty-eighth Senatorial District. Both members are from Allegheny County and will serve four year terms.

for medical care on trial in PSRO Area Four

system because it would be less costly and more convenient for patients."

Among the goals listed are: 1. Highest quality medical care for every patient; 2. comprehensive health care services through cooperation of all parties; 3. establishment of criteria and standards to measure proper medical care; 4. education of the public; 5. continuing education for physicians and other health care providers; and 6. a study of the advisability of "proceeding into the format of an Individual Practice Association."

The final goal might lead to the establishment in the area of a prepaid open panel group practice such as has functioned in certain areas of California for a number of years. Under the HMO Act of 1973, the Individual Practice Association (IPA) has been recognized as an alternate to HMOs, and HEW has published regulations for their use. Informational programs clarifying the ground rules under which an IPA could function under the HMO Act are currently being sponsored in three places in the nation by the American Association of Foundations for Medical Care.

Other temporary officers of the Eastern Pennsylvania Council are: Ralph L. Shields, M.D., Bethlehem, vice president; Sami Michael, M.D., Lehighton; secretary; Joseph W. Stella, D.O., Allentown; treasurer; and Robert R. Parsons, executive secretary of the Lehigh County Medical Society, executive director. Herbert Strohson, of Evergreen, Colorado, is consultant.

Nuclear chapter formed

The Pennsylvania Chapter of the American College of Nuclear Medicine held its organizational meeting on March 15. The purposes of the organization are to advance the science of nuclear medicine, improve nuclear medicine services to patients, study the socioeconomic aspects of the practice of nuclear medicine, and encourage improved and continuing education for practitioners of nuclear medicine. Any physician practicing nuclear medicine in the Commonwealth of Pennsylvania is eligible for active membership.

A constitution and bylaws was adopted and officers were elected during the meeting. Officers are: George L. Jackson, M.D., Harrisburg, president; John Hansell, M.D., Philadelphia, vice president; Donald Morel, M.D., Allentown, treasurer; Michael Dooley, M.D., Malvern, secretary; and Robert Bell, M.D., Downingtown, historian.

The Pennsylvania chapter has been formally recognized by both national colleges of nuclear medicine.

Dr. Sinclair retires from Blue Shield

Sidney E. Sinclair, M.D., retired March 31 after eleven years as Pennsylvania Blue Shield's executive vice president-professional affairs. Robert B. Edmiston, M.D., Harrisburg family physician, replaces him.

Dr. Sinclair had been responsible for development and enactment of medical policies and for liaison between Blue Shield and doctors through their professional societies. He was instrumental in developing the prevailing fee program in Pennsylvania and in implementing uniform procedure terminology. Dr. Sinclair also played a role in developing the current Blue Shield Corporate Membership Election Districts and in drafting the rules and regulations for participating doctors. He is a member of the Pennsylvania Medical Society House of Delegates, representing Lycoming County, and was honored for his service to the medical profession at the Society's 1974 Annual Session.

DR. SINCLAIR

DR. EDMISTON

Dr. Sinclair is continuing to serve Blue Shield in an advisory capacity. In mid-April he assumed the part time post of quality assurance coordinator at the Williamsport Hospital.

Pediatrics academy seeks consultants

The Pennsylvania American Academy of Pediatrics Day Care Committee has up to date information about health in day care for children and seeks to contact Pennsylvania professionals who are active or wish to be active as health consultants to day care, Head Start, nursery school or part-day child care programs outside of regular school throughout the Commonwealth.

For further information contact Susan S. Aronson, M.D., Chairman, Pennsylvania AAP Day Care Committee, The Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia, PA 19129; (215) 842-6543 during business hours; or contact T. Coleman, M.D., anytime (215) 735-1077.

Argonaut seeks premium hike at commissioner's hearings

Argonaut Insurance Co., of Menlo Park, California, sought a premium increase of almost 207 percent at the Insurance Department hearings on malpractice coverage in the Commonwealth March 18-20. Shown here are photographs of some of those who testified. See page 7 for additional coverage.

Vernon Buckley, D.O., and Alfred Grilli, D.O., Pennsylvania Osteopathic Medical Association

Jerrold V. Jerome, Argonaut Insurance Co.

James Neely, Hospital Association of Pennsylvania

John Kelley, city councilman, Galeton.

John Helwig, Jr., M.D., Philadelphia County Medical Society

Roger O. Egeborg, M.D., HEW

Robert E. Rinehimer, Pennsylvania Blue Shield

A LEGISLATIVE DINNER brought together government representatives and physicians of Delaware County on April 10, when legislation affecting medicine was discussed and physicians had the opportunity to meet their elected officials. Shown above, seated left to right, are William Y. Rial, M.D., vice speaker of the AMA House of Delegates; James B. Donaldson, M.D., president, Philadelphia County Medical Society; F. Peter Kohler, M.D., president elect, Delaware County Medical Society (DCMS); and James W. Dunn, M.D., cochairman, DCMS Commission on Legislation. Standing are Furman T. Kepler, M.D., president, DCMS; Lawrence Mellon, M.D., cochairman DCMS Commission on Legislation; Leonard Bachman, M.D., Pennsylvania's secretary of health; and Robert H. Craig, Jr., director of governmental activities for the Pennsylvania Medical Society.

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For more information, write:
Dept. of Circulation & Records, AMA,
535 N. Dearborn St., Chicago, IL 60610.

Atlantic City

See page 46 of the April PENNSYLVANIA MEDICINE for complete course lists.

trauma

WILLIAM P. GRAHAM, III, M.D.
STEPHEN H. MILLER, M.D.
ARTHUR M. CALABRETTA
Hershey

This paper was prepared by the division of plastic surgery of the department of surgery, Milton S. Hershey Medical Center, Pennsylvania State University, Hershey.

Dog bite!

Increasing numbers of people are acquiring large dogs ostensibly to protect their homes and loved ones from today's violent society. This demand makes German Shepherds one of the most popular breeds of dogs owned in this country. Recently one of the major news weeklies commented upon the increasing frequency of dog bite injuries from Saint Bernards. In the authors' experience, dog bite injuries result from German Shepherds more often than any other breed.

Injuries from dogs occur predominantly in two body areas—the head and neck and the upper extremities. Certainly the facial area is the one predominantly injured in children, as many of them are unprepared for the sudden lunge of the dog and do not guard their faces with their hands as adults tend to do (Figures 1-3).

Unlike the wounds inflicted by humans, dog bites when properly treated have a lesser tendency to become infected. An unusual hazard of animal bites is infection with pasteurella multocida. Fortunately this organism is sensitive to virtually all antibiotics.

Although the general rule is not to primarily close wounds resulting from human bites, with proper local treatment many injuries resulting from dog bites can be repaired initially. This is especially important in view of the high frequency of facial wounds inflicted by dogs. Puncture wounds, especially those through and through the hand should not be closed pimarily due to many poorly vascularized spaces within the hand. These wounds should be extended and left open for secondary closure rather than risk the possibility of a fascial space infection or later hemorrhage from injured vessels within the digits or palm.

Wounds that will be closed should be thoroughly explored after acquiring adequate anesthesia. The local skin is prepared with any usual surgical cleansing solution, avoiding the open wound. The wound is irrigated with a physiologic solution (lactated Ringer's), and the injured skin margins and traumatized fat are sharply excised. Depending upon the location and nature of the wound, closure may vary. Usually minimally reactive sutures (polyglactin) are used in the subcutaneous and subcuticular areas. Monofilament nylon is used for the skin closure. Drains are often employed. A recent preference has been the use of a 19 gauge scalp vein tubing connected to vacuum blood collecting tubes which are changed as needed. The drains can usually be removed in two to three days. Tetanus prophylaxis must be provided with these wounds. If adequate immunization has been given within the last year, it is not repeated.

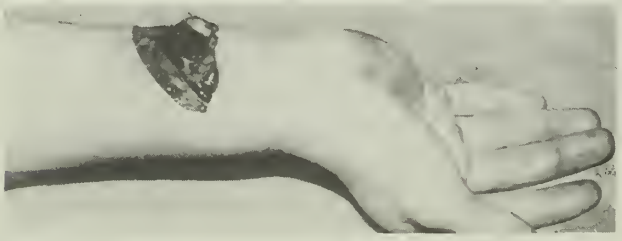

Figure 1. Lacerated right arm of 18-year-old man bitten by his brother's German Shepherd.

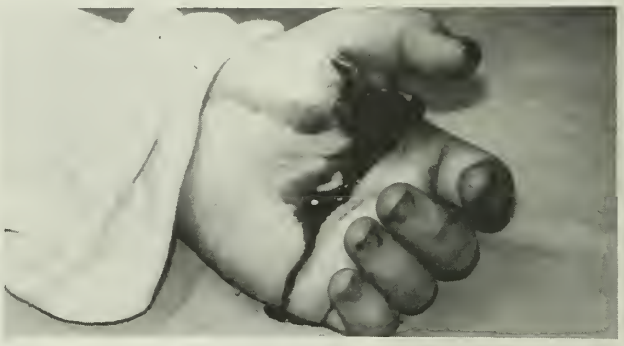

Figure 2. Torn thenar eminence and avulsion of motor branch of median nerves in the left hand of same man as in Figure 1.

Figure 3. Extensive ear laceration sustained by young man from a dog bite.

The animal must be reported to local authorities. If the animal cannot be identified, rabies immunization must be given. Systemic antibiotics are usually given for most of these injuries for five to ten days. Scar revisions, when indicated, can be performed six to twelve months after the injury once the wound has reached its maximum maturity. □

new members

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It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

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Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

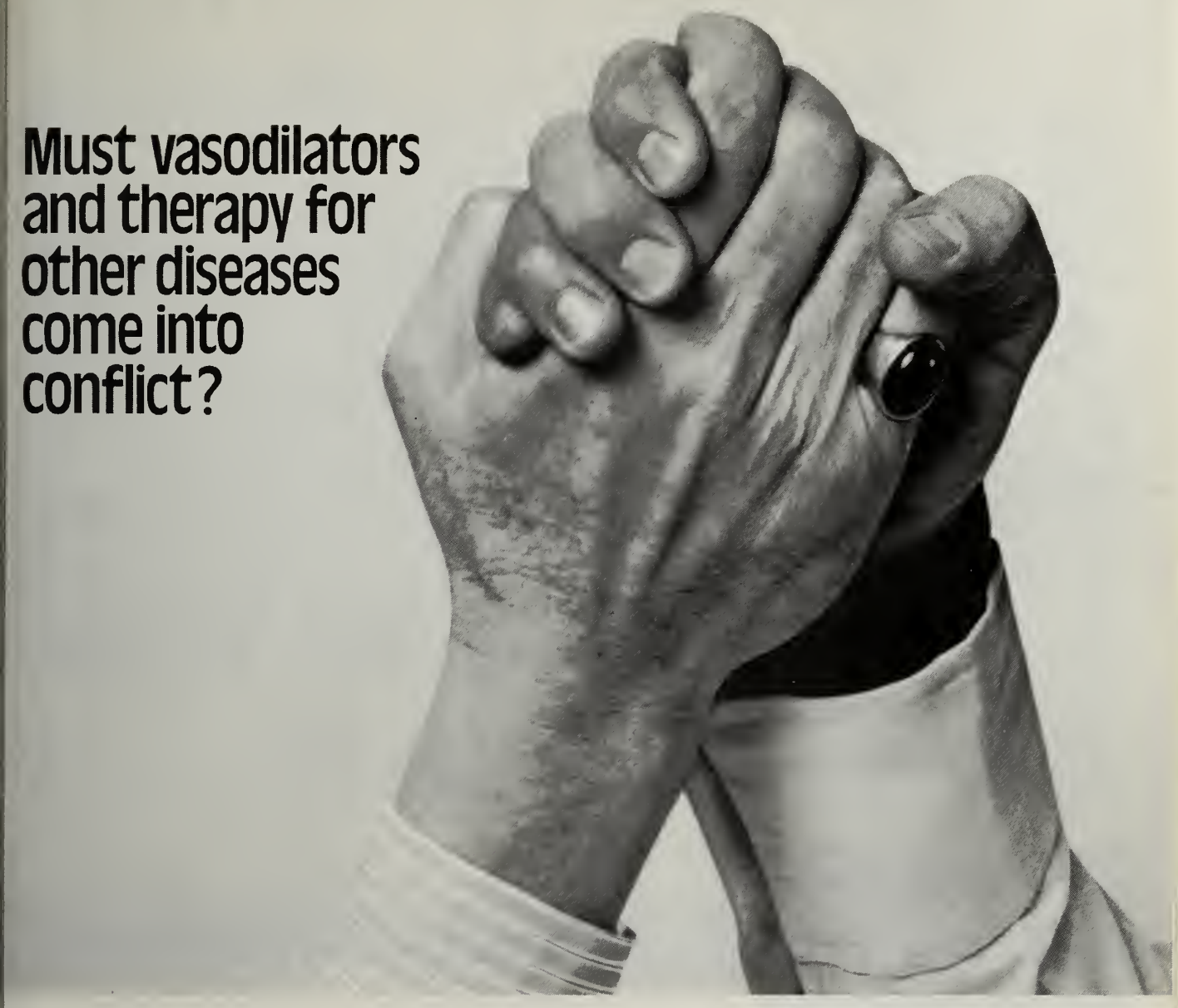
For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES INC
Deerfield, Illinois 60015

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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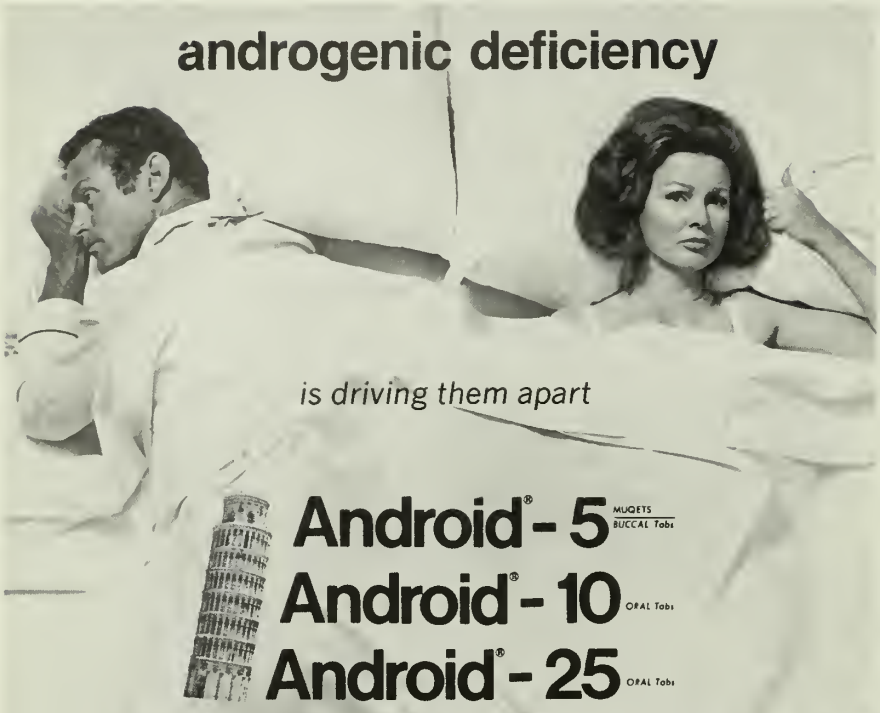
Mead Johnson LABORATORIES

When **impotence** *due to*

androgenic deficiency



is driving them apart

Android®-5 MUQETS BUCCAL Tabs

Android®-10 ORAL Tabs

Android®-25 ORAL Tabs

Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**

2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

COLD FEET
LEG CRAMPS
TINNITUS
DISCOMFORT ON STANDING

LIPO-NICIN®

gives you a choice for

IMMEDIATE or GRADUAL

nicotinic acid therapy

IMMEDIATE RELEASE		GRADUAL RELEASE
LIPO-NICIN/100 mg. Each blue tablet contains:	**LIPO-NICIN/250 mg.** Each yellow tablet contains:	**LIPO-NICIN/300 mg.** Each timed-release capsule contains:
Nicotinic Acid .....100 mg.	Nicotinic Acid .....250 mg.	Nicotinic Acid .....300 mg.
Niacinamide ..... 75 mg.	Niacinamide ..... 75 mg.	Ascorbic Acid .....150 mg.
Ascorbic Acid .....150 mg.	Ascorbic Acid .....150 mg.	Thiamine HCL (B-1) .... 25 mg.
Thiamine HCL (B-1) .... 25 mg.	Thiamine HCL (B-1) .... 25 mg.	Riboflavin (B-2) ..... 2 mg.
Riboflavin (B-2) ..... 2 mg.	Riboflavin (B-2) ..... 2 mg.	Pyridoxine HCL (B-6) ... 10 mg.
Pyridoxine HCL (B-6) ... 10 mg.	Pyridoxine HCL (B-6) ... 10 mg.	**DOSE:** 1 to 3 tablets daily.
DOSE: 1 to 5 tablets daily.	**DOSE:** 1 to 3 tablets daily.	**AVAILABLE:** Bottles of 100, 500, 1000
AVAILABLE: Bottles of 100, 500, 1000	**AVAILABLE:** Bottles of 100, 500, 1000	

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

WRITE FOR LITERATURE AND SAMPLES

BROWN **THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th St., Los Angeles, CA 90057**

REFER TO PDR

MDs in the news

Robert J. Slater, M.D., B. Sc., (left) was inaugurated as the fourteenth president of the Medical College of Pennsylvania in January. The occasion marked the beginning of a year long series of events celebrating the 125th anniversary of the founding of the college on March 11, 1850. With Dr. Slater is John E. Krout, chairman of the college's board of corporators.

Judith Weisz, M.D., was recently appointed chief of the division of reproductive biology in The Pennsylvania State University College of Medicine at The Milton S. Hershey Medical Center. Dr. Weisz is associate professor of obstetrics and gynecology and a senior member of the Penn State graduate school faculty. She is on the editorial board of *Endocrinology.*

Walter A. Redel, M.D., Waverly, was honored recently by the West Side Hospital and Community Medical Center, Scranton, for 50 years of service in the practice of medicine. Dr. Redel is on the staff of Community Medical Center as a general surgery consultant.

Renato Baserga, M.D., Ardmore, was recently named an advisor to the Special Cancer Program of the National Cancer Institute. Dr. Baserga is professor of pathology at Temple University School of Medicine and senior investigator at Temple's Fels Research Institute.

Charles Shagass, M.D., is serving as president of two national psychiatric societies for 1975: The American Psychopathological Association and the Society of Biological Psychiatry. Dr. Shagass is professor of psychiatry at Temple University and director of Temple Clinical Services at Eastern Pennsylvania Psychiatric Institute.

Peter Safar, M.D., professor and chairman of the Department of Anesthesiology in the School of Medicine, University of Pittsburgh, was recently appointed to the President's Interagency White House Committee on Emergency Medical Service Systems. The committee was established to coordinate the aspects and resources of all federal programs and activities which relate to emergency medical services. Dr. Safar has also been appointed to the steering committee of the Pennsylvania Emergency Medical Services Council.

Mayer A. Green, M.D., was recently installed as president of the American Association of Convalescent Homes and Hospitals for Asthmatic Children at the annual meeting in Bal Harbour, Florida. Dr. Green also served recently on the American College of Allergists' faculty on examination for fellowship.

Howard H. Weaner, Jr., M.D., was recently given spontaneous community recognition by citizens of Montgomery. At a testimonial dinner dance Dr. Weaner was honored as a 20 year resident and citizen. He is a trustee of the Pennsylvania Academy of Family Physicians and on the board of directors of the Lycoming County Medical Society.

Five Philadelphia scientists involved in cancer research have received new grants from the American Cancer Society. The grants total $344,034 and bring the sum of ACS research grants in affect in the Philadelphia area to $1,851,843. The recipients are: **Takashi Honda, M.D.,** department of radiation therapy and nuclear medicine at Hahnemann Medical College and Hospital; **Morris H. Ross, V.M.D.,** Institute for Cancer Research; **Barry S. Cooperman, Ph. D.,** department of chemistry, University of Pennsylvania; **Fred Karush, Ph. D.,** department of microbiology, University of Pennsylvania; and **Sidney Weinhouse, Ph. D.,** Fels Research Institute, Temple University.

The following Pennsylvania physicians were among those recently certified by the American Board of Family Practice: Kamal H. Aoun, M.D., Franklin; Robert L. Barton, M.D., Hershey; J. Robert Gavin, M.D., Scranton; Joseph J. Giombetti, M.D., Dunmore; Stanley M. Godshall, M.D., Rheems; G. Winfield Hedrick, M.D., Souderton; Theodore R. Kantner, M.D., Harrisburg; Chester T. Kauffman, M.D., Indiana; Dale L. Kemmerer, M.D., Phoenixville; E. Donald Kotchick, M.D., Scranton; Patrick A. Mazza, Jr., M.D., Reading; Alan F. Myers, M.D., Altoona; Melvin Oram, M.D., Scranton; Eugene G. Stec, M.D., Scranton; and W. Peter Stelmach, M.D., Reading.

MDs in the news

George C. Lewis, M.D., Wynnewood, recently received the American Cancer Society's National Divisional Award for Meritorious Service in the control of cancer. Dr. Lewis has served as a consultant in cancer detection and treatment for major hospitals throughout the Delaware Valley. He is professor of obstetrics and gynecology at Jefferson Medical College, Thomas Jefferson University.

DR. LEWIS

DR. COHEN

Stanley N. Cohen, M.D., was recently elected president of the Delaware Valley Affiliate of the American Diabetes Association at its annual meeting. Dr. Cohen is chief of the diabetes clinic of Thomas Jefferson Hospital and assistant clinical professor of medicine at Thomas Jefferson University.

Bruce D. Boselli, M.D., and **Gerald L. Mackler, M.D.,** were recently certified in the subspecialty of hematology by the American Board of Internal Medicine. Dr. Boselli is an associate professor and Dr. Mackler is a clinical instructor at Hahnemann Medical College.

S. Frank Hazen, M.D., recently received recognition from the State Society for his 50 years in medical practice. Dr. Hazen is a member of the American Academy of Ophthalmology and Otolaryngology and a life member of the Ex-residents of the Mayo Clinic.

Rudolf Sepic, M.D., Grove City, was certified as a diplomate of the American Board of Obstetrics and Gynecology recently. He is also a member of the American College of Obstetricians and Gynecologists.

Prabhaker G. Sardesai, M.D., Erie, was recently named a fellow of the American College of Cardiology.

Robert Jones, M.D., head of Harrisburg Area Community College's life sciences and physical education department, was recently elected chairman of the Emergency Health Services Council for 1975. The council draws members from related health care fields to coordinate emergency services in Dauphin, Cumberland, Lebanon, and Perry Counties.

The Dr. Meyer Bloom Scholarship Fund has been established at the University of Pittsburgh, Johnstown, to provide awards and grants-in-aid to premedical students. The fund was created by the family of Dr. Bloom on his 70th birthday anniversary.

William K. Grossman, M.D., Dallas, was recently appointed chief of psychiatry at Veterans Administration Hospital. Dr. Grossman is a research instructor of psychology and human behavior at Jefferson Medical College and chairman of the continuing medical education committee of the Luzerne County Medical Society.

Jack Greenberg, M.D., has been appointed clinical professor in the department of neurology of Temple University Hospital.

Three Alle-Kiski Valley doctors were recently cited by the State Society for 50 years of medical service. Honored were **Paul G. Bovard, M.D.,** Fawn Township, **James L. R. Young, M.D.,** Tarentum, and **Samuel G. Henderson, M.D.,** Clearwater, Florida.

A. D. Martin, M.D., was recently honored by the Colver community for his more than 50 years of service. The new medical facility, which began operation in March, was named in his honor; it is the A. D. Martin Community Health Center.

The junior medical students at Hahnemann Medical College and Hospital of Philadelphia recently presented awards for excellence in clinical teaching. Recipients were: **Harris Clearfield, M.D.,** associate professor of medicine and director of the division of gastroenterology; **Sigmund Benham Kahn, M.D.,** professor of medicine and clinical associate professor of pharmacology; **Elliott L. Mancall, M.D.,** professor of medicine and director in the division of neurology.

Gerhard Werner, M.D., professor and chairman of the department of pharmacology, has been appointed acting dean of the University of Pittsburgh's School of Medicine. He succeeds **Donald N. Medearis, Jr., M.D.,** who resigned recently to return to teaching and clinical practice.

The Medical College of Pennsylvania recently named two new department chairmen. **Rosalie Burns, M.D.,** Philadelphia, has been appointed chairman of the department of neurology and **Sumner Root Ziegra, M.D.,** Malvern, is the new chairman of the pediatrics department.

DR. BURNS

DR. ZIEGRA

The first president of the Pennsylvania Chapter of the American College of Nuclear Medicine (ACNM), elected at the chapter's organizational meeting, is **George L. Jackson, M.D.** Dr. Jackson is director of medicine at Harrisburg Hospital and is on the steering committee for the ACNM. He is certified by the American Board of Internal Medicine and on the Board of Regents of the American College of Nuclear Physicians.

MDs in the news

New officers

Chester County Medical Society
Nicholas F. Viek, M.D., West Chester, president
Richard H. Smith, M.D., Downingtown, president elect
Thomas E. Deutsch, Jr., M.D., Malvern, vice president
Thomas S. Johnston, M.D., West Chester, treasurer
Norman A. Goldstein, M.D., Phoenixville, secretary

Columbia County Medical Society
Peter Ringawa, M.D., Bloomsburg, president
Robert Hunter, M.D., Mountaintop, president elect
Ernest Campbell, M.D., Bloomsburg, vice president
J. Campbell Martin, M.D., Bloomsburg, secretary treasurer

Dauphin County Medical Society
Milton Friedlander, M.D., Camp Hill, president
Paul F. Kase, M.D., Harrisburg, president elect
Bernard Margolis, M.D., Harrisburg, 1st vice president
Hiram Wiest, M.D., Hershey, second vice president
David A. Smith, M.D., New Cumberland, secretary treasurer

Erie County Medical Society
James F. Walker, M.D., Erie, president
Anthony T. Merski, M.D., Erie, president elect
Douglas B. Nagle, Jr., M.D., Erie, vice president
Robert J. Demuth, M.D., Erie, treasurer
John P. Mraz, M.D., Erie, secretary

Fayette County Medical Society
Florencio Cardenas, M.D., Uniontown, president
William Mitchell, M.D., Uniontown, president elect
Cataldo Corrado, Jr., M.D., Uniontown, first vice president
Roldan Medina, M.D., Uniontown, second vice president
Gertrude Blumenschein, M.D., Uniontown, secretary treasurer

Luzerne County Medical Society
Francis J. Menapace, M.D., Wilkes-Barre, president
Joseph T. Buckey, M.D., Mountaintop, president elect
Joseph W. Ehrhart, M.D., Forty Fort, vice president
Edward A. Lottick, M.D., Kingston, secretary
Stanley C. Ushinsky, M.D., Kingston, treasurer

Hazleton Branch
Robert J. Gibbons, M.D., Hazleton, president
Anthony G. Stish, M.D., Hazleton, vice president
Herman L. Auerbach, M.D., Hazleton, secretary treasurer

McKean County Medical Society
Frederick R. Gabriel, M.D., Bradford, president
Thomas Burkart, M.D., Bradford, president elect
Thomas Logio, M.D., Kane, vice president
Elizabeth Cleland, M.D., Kane, secretary treasurer

Northumberland County Medical Society
Dennis R. Mychak, M.D., Mt. Carmel, president
Clyde H. Jacobs, M.D., Sunbury, president elect
Benjamin M. Broscius, M.D., Shamokin, vice president
G. R. Wentzel, M.D., Sunbury, secretary
W. W. Christman, M.D., Sunbury, treasurer

Westmoreland County Medical Society
Frank D. Edgar, Jr., M.D., Greensburg, president
R.G. Sarver, M.D., Latrobe, president elect
R.M. Doncaster, M.D., Greensburg, vice president
Eugene W. Herron, M.D., Export, secretary
Joseph F. Bucci, M.D., Scottdale, treasurer

York County Medical Society
Thaddeus Lekawa, M.D., York, president
William M. Shue, M.D., York, president elect
John J. Danyo, M.D., York, vice president
John P. Whiteley, M.D., York, secretary treasurer

continuing education

This issue carries no education course listings. The January issue contained a supplement—a comprehensive list of education courses being offered in all parts of Pennsylvania. Consult that issue or write for a copy of the supplement to: Pennsylvania Medical Continuing Education Institute, 20 Erford Rd., Lemoyne, PA 17043.

MDs in the news

Your man in Lemoyne

Raymond C. Grandon, M.D. - Fifth District

DONNA WENGER
Communications Division

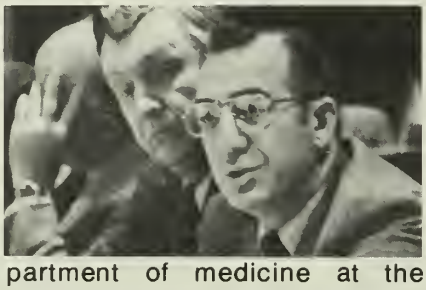
The temptation is to say "You name it; he's done it." For Raymond C. Grandon, M.D., that is as true as for anyone in medicine in Pennsylvania.

Born, raised, and schooled in the central Pennsylvania area, Dr. Grandon has lived and served in that area, leaving it only a few times for educational or military reasons. With a B.S. degree from Dickinson College in 1942, Dr. Grandon received his medical degree from Jefferson Medical College in 1945. He served his internship at St. Luke's Hospital in Bethlehem, Pennsylvania, and then his residency in internal medicine at Harrisburg Hospital from 1948 through 1950.

While serving in the U.S. Army, from 1946 to 1948, Dr. Grandon was a professional trainee in psychiatry, at Mason General Hospital on Long Island. For a time he considered choosing psychiatry, but eventually settled on internal medicine which has since been the focus of his practice. He has been active in both the Pennsylvania Society of Internal Medicine, having recently been elected to a second term as president, a singular honor, and in the American Society of Internal Medicine, serving as a delegate for the past three years.

These involvements in specialty society activities are part of Dr. Grandon's commitment to the entire area of organized medicine. From early activities in the State Society's Commission on Medical Education, when he set up hospital training programs around the state, to secretary for three years prior to his election in 1973 as trustee and councilor of the Fifth District, Dr. Grandon has devoted much time to organized medicine. State Society activities balance with Dauphin County Medical Society activities, where he held every elective office, including secretary treasurer for 10 years and the presidency in 1971.

Community activities (Homemakers Inc., United Fund, Pennsylvania Department of Health Alcohol Counseling Center) and other medical involvement in medical school alumni and voluntary health organization, have been as much a part of Dr. Grandon's life as organized medicine. Presently he is clinical assistant professor in the department of medicine at the Pennsylvania State University College of Medicine. In 1973 Governor Milton J. Shapp appointed Dr. Grandon to the State Board of Medical Education and Licensure.



Of particular interest to Dr. Grandon are the cardiac aspects of internal medicine. While still a resident he interested a local baker to make salt free bread available to cardiac patients in Central Pennsylvania. He was responsible for the first congenital heart operation in Harrisburg and was responsible for the idea, fund raising, and production of the first live TV heart operation (Presbyterian Hospital, Philadelphia to Harrisburg area over WTPA) program. More recently he has devoted his attention to cardiac rehabilitation, which led to his co-founding of the first CPR (Cardiac-Pulmonary Rehabilitation) Center in the country, a concept that has since spread nationwide.

That Dr. Grandon has served so actively assures his response to many current situations, including the need for increased physician-public communication. "While there is a need for government regulations, more important is the need for increased dialogue between government and organized medicine. More liaison at the appropriate committee level is needed; we can never have enough of this. The results of such interchange of ideas could lead to satisfactory resolutions of issues as they surface and awareness of the other's view. Our legislators must become more aware of the health and medical issues. Not only is education of the legislator important but also that of the patient. The cost and effectiveness of medical care is so dependent upon patient education that I devote much of my time to this aspect."

For a man so involved with his profession, who by his own estimate gives it 30 to 40 hours a week beyond his private practice, one can ask "How and why do you do it?" Dr. Grandon's response is simple. "If I feel I have something to contribute, then I try to do it. My guiding concerns are humanity and medicine; where I can serve and lend my expertise, that's where I work."

Joseph M. Stowell, M.D.—Sixth District

DEBORAH L. RUSSELL
Editorial Assistant

After World War II, Joseph M. Stowell, M.D., after investigating practice possibilities on the eastern coast, decided to settle in Pennsylvania to practice general surgery. At the time Altoona seemed the best location as Dr. Stowell's wife had been raised

there. He has practiced there ever since.

Joseph May Stowell, born July 17, 1909, in Dublin, New Hampshire, received all but one year of his education outside of Pennsylvania. He earned his Bachelor of Science degree at Massachusetts Institute of Technology in 1932 and his medical degree four years later at Tufts Medical College. His internship and residency were at Albany Hospital, Albany, New York. He then served in various locations in Massachusetts. He was a fellow in orthopedics at the Lahey Clinic in Boston, house officer in gynecology at the Free Hospital for Women in Brookline, resident in cancer at Pondville Hospital, Wretham, and a fellow of the Tumor Clinic, Massachusetts General Hospital.

Dr. Stowell, having served previously as a second lieutenant in the United States Army Reserve in chemical warfare, went on active duty in 1944 in the Navy Medical Corps where he was assigned to the surgical services. He was lieutenant senior grade in the U.S. Naval Reserve until 1965.

The year 1950-51 Dr. Stowell spent at the Graduate School of Medicine of the University of Pennsylvania. He took a refresher course in general surgery, which, as he looks back on it, was a "tremendous help" in his practice.

A former member of the Massachusetts Medical Society, Dr. Stowell joined the Blair County and State Societies when he and his wife settled in Altoona. He was president of the county society in 1957, served as an alternate delegate in the House of Delegates until 1973, and was a delegate at the 1974 Annual Session.

As a new member of the Board of Trustees and Councilors, Dr. Stowell's concept of the Board's function and purpose is "to carry on the will of the House of Delegates in helping solve the many and severe problems that confront medicine today. . . . It is our feeling that organized medicine should take an ever increasing part in the problems of medicine both in the delivery and in its economics."

Dr. Stowell is currently a member of the Pennsylvania Medical Political Action Committee, the Benjamin Rush Award Committee, the Publication Committee, and the Committee on Relations with Allied Professions.

Active in numerous organizations, medical and otherwise, Dr. Stowell believes that benefits from membership depend on "the amount of effort that one puts into the various societies." He has motivations, besides action, for belonging to societies. "They are a means of meeting and making new friends. It is in a national society one makes friends from other parts of the country. Professional societies do a tremendous amount of distributing medical knowledge and helping to keep one up to date in his particular specialty."

Dr. Stowell is a fellow of the International College of Surgeons, American College of Surgeons, American Society of Abdominal Surgeons, and the Lahey Clinic Alumni. Memberships include the AMA, Wainwright Tumor Clinic Association, and the Blair County Chapter of the Pennsylvania Cancer Society, among others. "The societies such as the American Medical Association and the Pennsylvania Medical Society are a means of expressing, as an organization, our opinions in the conduct of medicine and what should be done on the national scene. It is our feeling that one individual has no weight, and the only way we will be heard in the legislative halls is by organization."

Drs. Gehris, Stowell, and Keck at Publication Committee meeting.

editorials

May — memorable month for medicine

History is probably the single most important bequest that can be left to any country or individual. Many Americans have come to regard their own heritage and that of others as rather commonplace and dull. Perhaps the fault for this injustice lies in our method of transmission. True history is not a simple calendar of dates and places. Neither is it a place to turn to when the present seems overwhelming. Nostalgia is hindsight and dwelling in it inhibits growth.

History must be relived through people and ideas. Only then can the truly magnificent achievements man has made be fully appreciated. Contributions of thought and invention from the minds of the past, used wisely, will serve as a guide for the present and as a solid foundation for the future. Alfred Stille, (1813-1900) director of medicine at the University of Pennsylvania, succinctly stated the application of history to medicine in the *Medical News* in 1884. "Medicine, like all knowledge, has a past as well as a present and a future and . . . in that past is the indispensable soil out of which improvement must grow." The month of May provides several examples from medicine's past that have become the foundations of modern medical care.

Where would many of us be without our stethoscopes? A ubiquitous piece of equipment in the modern medical world, the stethoscope was unknown until Rene Laennec's discovery of it May 1, 1815. His first listening device consisted of a sheet of paper, rolled and tied with a string. After some experimentation, Laennec produced a wooden tube approximately twelve inches long, one and one quarter inches in diameter with a quarter inch hole through the center. For ease of transportation, it separated into two six inch sections. Armed with his new invention, Laennec listened, but what did he hear? Today we might associate cracks and rales with penumonia, *but in 1815 no one knew which sounds were made by what disease.* Laennec began to record the sounds he heard in living patients and correlated them with the findings at autopsy. Results of the studies were published in his book, *De l'auscultation mediate*, which has earned him the title of Father of Chest Medicine.

Edward Jenner, born May 17, 1749, performed the first vaccination for small pox on May 14, 1796. The recipient was an eight year old boy, James Phipps. Jenner's experiment proved so successful that Napoleon ordered his army immunized. How many deaths would have resulted from controllable diseases like small pox over the past two centuries were it not for the discovery of vaccination? Today, with routine immunization schedules, a small pox epidemic, although not outside the realm of imagination, is an extremely unlikely occurrence.

All knowledge begins with experience. The mind of today is no better than that of the past. There is a greater fund of knowledge available with which to build. By applying the experience of others handed down through history and our own cognition, opportunities for advancement are boundless.

David A. Smith, M.D.
Medical Editor

The open-end standing order— a luxury we cannot afford

Time is past due for a critical examination by physicians of their practice of writing open-end standing orders on hospital charts. When hospitals eliminated open-end standing orders for habit-forming, dangerous, and cumulative drugs physicians protested briefly but soon realized that their prerogative to write sensible closed-end standing orders was unabridged. They soon learned that prescribing drugs for a reasonable period of time or a reasonable number of doses was sound medical practice. Two lines of defense were established to protect the patient against injury from excessively long drug usage: the physician's own closed-end orders and the hospital's policy about the interpretation of open-end standing drug orders. Now we need to consider extending those standing order regulations, which have been so successful in drug therapy, to certain nursing and laboratory procedures.

A conscientious physician has difficulty defending the unnecessary nursing and laboratory work initiated by open-end standing orders. How many physicians have seen daily coagulation studies continue for days or even weeks after anticoagulant therapy ceased, blood studies done every six hours to detect gastrointestinal bleeding right up to the hour of discharge from the hospital, or daily weight by bed-scales on ambulatory pa-

tients? The total cost in poor morale and extra personnel to the supporting services—not to mention the unnecessary venepunctures and inconvenience endured by the patient—though difficult to measure is easy to imagine. If we don't write our own self-limiting standing orders to control the excesses brought about by open-end standing orders, regulatory services might preempt the privilege and forbid us to write any kind of standing orders.

Although some hospitals have evolved policies controlling unlimited standing orders for various nursing and laboratory procedures, the practice is not widespread. Perhaps the most common policy is one requiring that orders be rewritten weekly. Other hospitals have set limits on the duration of certain treatment, e.g., inhalation therapy. Perhaps the most authoritarian approach is the one that considers any standing order to be for one treatment or one day only, unless otherwise specified.

We physicians should resolve to set up two lines of defense against the abuses brought about by unbridled standing orders: (1) by resolving to write self-limiting standing orders ourselves, and (2) by establishing hospital staff policies controlling standing orders through our hospital staff organizations. If the policies are written correctly the second line of defense, the hospital staff policy, would come into play only if the physician himself failed to write for a reasonable duration or number of procedures, treatments, or observations. Neither our economy, our supporting staff, nor our patients can afford the luxury of open-end standing orders.

Robert H. Kough, M.D.
Contributing Editor
Danville

correspondence

State contributes to increasing medical costs, writer says

To the editor:

In his recent message on the State of the Commonwealth, Governor Milton Shapp pledged the efforts of his administration to work on the problem of the increasing costs of medical care. I wrote to him with my congratulations for his intentions, certain that all Pennsylvania physicians are aware of this problem and willing to find remedies.

Aside from the general state of the economy, including increasing costs for each of us, there is a major problem specific to physicians who treat beneficiaries of the Department of Public Welfare—the so-called DPW patients.

Payment by the department for this care is at a rate well below the "usual rate" which other patients pay. As much as 60 percent of the gross billings of a family doctor may go to office expenses such as personnel salaries and office maintenance. Payment by the Commonwealth for DPW patients is just enough to cover these expenses and there is little left for the doctor himself. This has two effects.

The most obvious effect is that a physician is not very eager to provide these services at all. It is a common experience, and a common complaint, that many DPW patients have a hard time finding a doctor to take care of them. Not the doctor, but rather the department, is to blame for its inadequate payment. Grocery stores, utilities, gasoline stations, and clothing merchants all receive their usual payments whether the customer is on assistance or not.

The second effect is of more general interest and importance. In order to earn an income to meet his personal expenses, a physician needs to see and treat a certain number of patients. If all his patients were paying "full fee," they would all share alike in the expense of receiving medical care. A family doctor gets to keep as his income $.40 for every $1.00 billed. But if 20 percent of the patients contribute little more than their share of the office overhead expenses, all the doctor's earnings must come from the other 80 percent. In such a situation four other patients help support the care of each DPW patient.

What this really amounts to is a discriminating taxation to support the program, over and above the state taxes all of us already contribute to it. A patient whose doctor also treats DPW patients may support the present DPW program with as much as 8 percent of his doctor bill (⅕ of the "$.40 on the dollar"). That 8 percent is a part of the cost of medical care which our state government could eliminate all at once or in a series of steps over the next year or so.

This is what I proposed to Governor Shapp, and I am happy with his answer that he will do what he can. Hopefully, the administration and our legislators can soon begin to lift this unfair burden from those taxpayers who happen to be ill and

whose doctor is nice enough not to refuse care to DPW patients.

As a beneficial side effect of such an improvement, the DPW patients will also discover that it has become easier to find a physician who is willing to take care of them. And that is what the whole medicaid program was about when it started ten years ago.

Jan R. J. deVries, M.D.
Boswell

Wants new education materials

To the editor:

Your excellent publication has again reminded me that time is indeed "running out" and for the life of me, I am unable to find the necessary forms, etc. for my Physician's Recognition Award.

Please be kind enough at your convenience to send me the necessary material so that I can do the best I can to send in my data to the best of my abilities to recapture all of the hours I have accomplished during these past three years.

Solomon S. Brav, M.D.
Philadelphia

Appreciates flood aid

To the Pennsylvania Medical Society:

Enclosed please find my check in the amount of $2,270 which, according to my records, should complete payment of my flood loss loan in 1972. The total loan was $5,000.

I shall always be deeply grateful for the granting of the loan which helped a great deal in our recovery. My wife joins me also in thanking you for your kindness and generosity in our time of need.

Will you kindly send me a receipt in full for my records. Thank you.

A Flooded Physician

practice management

Handling medicare overutilization refund claims

LEIF C. BECK, LI.B.
VASILIOS J. KALOGREDIS, J.D.
Bala Cynwyd

Authors' note: A recent series of articles in PENNSYLVANIA MEDICINE was intended to acquaint doctors with important aspects of the medicare program. By way of supplementing those articles written by Mr. Perkin of Pennsylvania Blue Shield, we believe it appropriate to make some suggestions for the doctors' protection. These comments deal with the growing problem of medicare claims for refund of fees for services alleged not to be "reasonable and necessary."

Overutilization claims by Blue Shield on behalf of medicare are relatively new experiences for ethical physicians. The power to seek refunds of payments previously made to doctors emanates essentially from amendments to the medicare law in 1972, and it appears to us that active refund efforts are just beginning to be recognized. As a result, we believe some doctors have been poorly prepared for extremely difficult and sometimes professionally infuriating administrative procedures.

We hope that our explanation of the procedures and what doctors should do to protect themselves will thus be helpful.

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.

Importance of adequate records

Perhaps the most important piece of advice for physicians is the oft-repeated, "Keep good charts and records." They are, of course, the keys to successful resistance to so many refund inquiries that we feel a physician must seriously consider conceding to such claims if his records do not show good reasons for his actions—even if those reasons existed.

While this need for written proof is well known today in view of malpractice trends, peer review, and the like, some physicians have begun to improve their own techniques. As one unfortunate example, only in 1972 did it become well publicized that attendings must at least countersign residents' progress notes to show that they had also seen the patients involved. Despite this, medicare overutilization refund claims have been dating back to earlier years based on the lack of proof that a hospital visit was actually provided by the attending. Attempting to establish today facts under retroactively applied rules is indeed exasperating.

As to the above situation involving hospital visits, we

urge doctors to countersign progress notes and to add at least some words of their own to establish their daily presence. It may not help the five year old records, but at least it may help protect records of present services.

Pre-1972 activities

Apparently, statutory authority to seek refunds for overutilization arose only in the medicare law amendments which took effect on October 30, 1972. Refunds are being sought by Blue Shield and the other medicare carriers, however, for services performed *before* that effective date. This presents the question whether Blue Shield has the legal authority to recover any amounts it paid out before then.

The Federal District Court for the Southern District of Florida considered this question and decided *against* medicare. It concluded that the carrier could not recover fees paid to the physician involved prior to the 1972 date even if there had been overutilization. That case is the only authority at this time, and it thus suggests that refund claims for earlier years are not effective.

Medicare has appealed that court decision and has instructed Pennsylvania Blue Shield and other carriers to disregard it at least until the appellate court has decided. We believe the lower court's decision to be sound, in which case refund actions for earlier years should be resisted by the doctors.

Dealing with the medical advisor

Initial discussions with the Blue Shield utilization representative are, of course, the first opportunity to establish that there are no real overutilizations. At this point, certain procedures and/or patient situations will have been pulled for inquiry.

We believe that extensive efforts of proof cannot begin early enough and we urge doctors to give their maximum attention to these earliest meetings. That they may be disruptive of a busy doctor's schedule is unfortunate, for if the claim is to be resisted at all, efficiency demands immediate attention to avoid later and greater time losses.

Unless the case is dropped at that early stage, which we would consider abnormal, it will be referred for the opinion of one of Blue Shield's medical advisors in the doctor's specialty. While his advice is not binding on Blue Shield, we believe it is imperative for the doctor to convince this advisor that the services were reasonable and necessary.

In some cases, doctors appear not to have realized the importance of this advisory stage. They are invited to present any materials or information they consider necessary, but the invitation does not in our opinion convey any particular emphasis. We know doctors, for example, who never really appreciated the opportunity to appear *in person,* with legal or other advisors and possibly even with witnesses to present the strongest case to the advisor. Failure to close out the case favorably at this level creates such a rocky road that we urge doctors to treat it as if the advisor were the final arbiter.

PMS advisory boards

Pennsylvania Blue Shield also cooperates by requesting review of many cases through the Pennsylvania Medical Society's advisory review program. The doctor may thus present information relative to the claimed refund situations for review by a panel of Society members in his specialty. As with Blue Shield's own advisor, any decision in favor of the doctor would be extremely valuable.

The panel of PMS advisors meets only occasionally, so the opportunity to appear in person with a well-presented case is somewhat limited. Furthermore, the advisory program can be misleading in understating a doctor's opportunity to present his case. He is invited to "submit any information," but this does not directly suggest appearing in person with maximum effort.

Appearances before the Blue Shield advisor and the State Society committees are, by the way, the only opportunities to present a doctor's case before *physicians.* All the other steps, including ultimate trial in court, are before laymen. Since both these two advisory steps may be fairly early in the refund case's procedural program, we urge again that the doctor take them seriously. He should treat them as though they were trials, using his attorney to assist in most effective presentation.

Possible compromises

The Blue Shield representatives are not officially permitted to settle a case by compromise. In fact, compromises appear possible by a doctor's agreeing to

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overuse on some transactions while the Blue Shield representative accepts explanations as to other transactions. Our clients often refuse this possibility when the principle involved is more important than the dollars, which is often the case when medical judgment is questioned, but the knowledge of this unstated opportunity can be helpful.

If the case is still open after the advisors have announced their findings, a very strong "club" will come out of Blue Shield's arsenal. It is a statement that unless the case is then closed by payment Blue Shield will have to "readjudicate" the claim. Readjudication involves computer review of a statistical sample of *all* the doctor's medicare claims to quantify the total overutilization in that sample. The dollar overutilization found in that sample would then be applied to the total of all claims by the doctor, with the result becoming medicare's official refund claim.

Perhaps a simple example will help describe the readjudication procedure and its perils. Suppose a doctor has been asked to refund $2,500 as 1973 overutilization with respect to ten patient matters. Upon readjudication, however, the risk exists of finding perhaps $1,000 of abnormalities in a 5 percent sample of his 1973 claims. Applying it to 100 percent of his claims for that year would result in an official refund action of $20,000 for that year alone. This would be eight times the amount which the doctor could have conceded and paid prior to the readjudication!

Blue Shield is careful to point out that the statistical review could work either for or against the doctor. Nevertheless, the uncertainty and the mathematical possibilities of escalating the dollars involved imposes tremendous pressure upon the doctor to compromise or concede his case. We believe it is an unfair weapon held back partially for this effect, and it is another reason why we believe maximum effort must be given to close the case at the earlier advisory levels.

The fair hearing

A doctor may at any point, but usually after the medical advisory hearings, request a "fair hearing." This is the medicare official administrative procedure with appropriate guidelines presumably guaranteeing impartiality and due process. The "fair hearing officer," however, is generally an attorney employed by Blue Shield and assigned to its medicare program. We feel the step should certainly be taken if a refund claim is being resisted, but we are not overly enthusiastic as to the likelihood of success.

The fair hearing could be a long and drawn out affair involving case by case proof as to each item raised in the readjudication's computer-developed statistical sample. The cost in time, legal fees, and frustration could be substantial, but it is a necessary step in continuing to resist alleged overutilization.

Government collection

The fair hearing officer's decision may not be appealed. Therefore, a decision against the doctor requires either his payment of the refund or his continued refusal. Such a refusal would cause the case to be referred to the Federal Government as an "uncollectible overpayment." While there would be opportunities for conferences leading perhaps to possible settlement, a case reaching this level is essentially ticketed for court action.

A doctor convinced of his case might welcome the trial possibility to vindicate himself, but most certainly want to avoid it. The publicity and the legal costs alone would typically lead to this decision.

Conclusion

Medicare overutilization refund actions are becoming more common but are not yet well understood by doctors or their attorneys. They can be extremely difficult matters involving inordinate amounts of time and costs for physicians who resist them. And many physicians will and should resist them since they challenge their bona fide medical judgment.

In resisting a refund action, however, a doctor should enter into the earliest stages with maximum effort. He should recognize the critical nature of the medical advisory meetings and treat them as if they were his last legal opportunity for success. Such preparation will in the long run reduce his time and financial demands and help reach a fair result with minimum anguish. □

Secondary repair of common bile duct injuries

CHARLES FINEBERG, M.D., F.A.C.S.
JOHN Y. TEMPLETON, III, M.D., F.A.C.S.
Philadelphia

Injury to the common bile duct during cholecystectomy is one of the most distressing complications encountered in abdominal surgery.[1,2] Unfortunately, procrastination in treatment often follows the onset of jaundice in a patient who has been subjected to cholecystectomy. Although an iatrogenic factor such as trauma or division of the common bile duct is the usual cause of a rapidly occurring jaundice in the postoperative period, decompensation of a liver that has borderline function, infectious hepatitis, hemologous serum hepatitis, or Halothane toxicity, may also be the cause of the jaundice.[3] The surgeon hesitates to subject the critically ill patient to another surgical procedure to determine the cause of the difficulty. These considerations often lead to prolonged delay in diagnosis and treatment of the patient with this unfortunate complication.

Common bile duct obstruction has a devastating effect upon the liver. Progressive dilatation of the entire intrahepatic biliary tree occurs rapidly. With increased pressure within the biliary tree, cellular atrophy, ascending infection, recurrent high fever and septicemia are not uncommon. If the obstruction is not relieved, the infection is likely to result in extensive replacement of hepatic cells with fibrous and fatty infiltration.

On admission the patient was observed to be moderately icteric, with a palpable spleen and liver.

Progressive disease of the liver is characterized by generalized debility, jaundice, hemorrhagic diatheses, ascites and eventual death of the patient. In view of the essential role played by the liver in numerous physiologic processes, it is deplorable that injuries to the common duct during abdominal surgery are frequently either improperly diagnosed or treated. Particularly discouraging is the delay which makes correction and possible salvage difficult.

In this paper we are presenting six cases of common duct injury incurred during intra-abdominal operations in which delay or inappropriate treatment complicated the effort to correct the injury. There had been one or more previous attempts to repair the common bile ducts in five of the six cases. Methods of diagnosis, preoperative preparation and operative techniques utilized in caring for these patients will be discussed.

Figure 1. Case 1. Intrahepatic choledochojejunostomy.

Case reports

Case 1: A 44 year old white woman, following cholecystectomy six years previously, exhibited jaundice immediately after the surgery. She was asymptomatic except for pruritis which lasted four months. A "bile duct operation" was performed four months after cholecystectomy; her jaundice subsided temporarily. In the subsequent five years she experienced intermittent jaundice, tarry stools and nausea three to four times a year. A biliary cutaneous fistula developed spontaneously; this was accompanied by profuse drainage and improvement of her condition.

Upper gastrointestinal x-ray revealed an ulcer in the middle third of the lesser curvature of the stomach. The patient was placed on a strict medical regimen, including tube feedings for the gastric ulcer which decreased to one half its original size in two weeks.

Three weeks after admission, exploratory laparotomy was performed through a right thoracoabdominal incision. The distal common duct was completely obliterated with a small fistula between the proximal portion of the common duct at the liver hilum and the second portion of the duodenum. The fistula was divided and the opening into the duodenum closed. The intrahepatic portion of the common duct was located by dissecting the hilum of the liver and removing a small core of hepatic tissue. An intrahepatic choledochojejunostomy utilizing the Roux-en-Y technique was performed.

The postoperative course was uncomplicated. Just before discharge twenty days after surgery a T-tube cholangiogram (Figure 1) revealed normal filling of the hepatic ducts with incomplete filling of the proximal portions of the left hepatic branches.

Three months later a T-tube cholangiogram was completely normal and the T-tube removed. The patient has remained asymptomatic for the past fifteen years.

Case 2: A 38 year old white woman had a cholecystectomy performed at another hospital. The postoperative course was stormy

Drs. Fineberg and Templeton are professors of surgery at Jefferson Medical College, Thomas Jefferson University.

with fever and continuous bile drainage from the wound. Findings at the time of a second laparotomy six months later were a stenosis of the common duct at the level of the cystic duct and a fistula between the proximal portions of the common duct and duodenum. The fistula was divided and the duct reconstructed over a #20 T-tube. The patient did poorly following surgery; serum bilirubin was elevated and there was very little T-tube drainage. She was then transferred to Jefferson Medical College Hospital on the service of another surgeon.

The patient was found to be cachectic, icteric, and to have an

Figure 2. Case 2. Intrahepatic choledochojejunostomy.

enlarged tender liver. The patient's condition in the hospital deteriorated and she ran spiking temperature elevations to 103 F. An emergency laparotomy was performed three days after admission and subhepatic and pelvic collections of bile were drained. Severe postoperative electrolyte imbalance was treated with intravenous fluids and gavage feedings to which the biliary drainage, amounting to 500 to 1000 ml daily, was added. The patient was discharged two months after admission with instructions to continue to take bile orally.

She was admitted three months later and a choledochotomy was performed without the use of an internal shunt. Her postoperative course was complicated by an active psychosis. After psychiatric consultation the patient was discharged.

The patient, having had four bouts of jaundice since repair of her common duct, was readmitted two years later. She had received electroshock therapy for chronic progressive psychosis and had undergone a mastectomy for carcinoma of the breast six months before.

On admission she still appeared cachectic and icteric. Through a thoracoabdominal incision an intrahepatic choledochojejunostomy was performed utilizing a Roux-en-Y procedure. The anastomosis was splinted by means of a large T-tube inserted through an opening in the jejunum and extending through the anastomosis into the common intrahepatic duct. Her postoperative course was uncomplicated and she was discharged thirty days later.

A T-tube cholangiogram four months later revealed a normal left hepatic ductal system. The anatomy of the right ductal system was not demonstrated (Figure 2). The T-tube was removed and the patient discharged to the care of her own physician. At the present time, twelve years following surgery, the patient is well with no recurrence of biliary tract symptomatology.

Case 3: A 31 year old woman was admitted with the chief complaint of jaundice and pruritis. Her gall bladder had been removed at another hospital three months previously. Physical examination showed an icteric female with a smooth, palpable liver.

An exploratory laparotomy performed one week after admission revealed a stricture in the midportion of the common duct with complete fibrosis and obstruction. The obstruction was excised and the proximal and distal portions of the duct dilated with Bake's dilators. The proximal and distal portions of the duct were anastomosed over a #16 T-tube which was introduced through a separate incision in the distal portion of the common duct. The proximal limb of the T-tube was split so that one half of the tube was positioned in the right and left hepatic ducts.

The patient's postoperative course was uncomplicated and a T-tube cholangiogram revealed free egress of dye into the duodenum (Figure 3). The T-tube was removed five months after discharge. The patient has remained well for the past thirteen years.

Case 4: A 61 year old male, who was admitted with a history of continuing jaundice, had had a cholecystectomy performed in another hospital three months previously. Immediately following the operation he became jaundiced and noted light-colored stools and dark urine.

Exploratory laparotomy was performed ten days after admission. A moderate sized stricture of the common duct was found and excised, drained and cultured. Bake's dilators were easily passed through the proximal common duct into both lobes of the liver. A #16 T-tube was inserted into the distal end of the common duct through an incision in its wall. The proximal limb of the tube was split and introduced

Figure 3. Case 3. Choledochodochostomy.

through the proximal common duct into the right and left hepatic ducts. The common duct was anastomosed over the limb of the T-tube.

The patient's postoperative course was uncomplicated. A T-tube cholangiogram revealed satisfactory emptying of the dye into the duodenum (Figure 4). The patient was discharged sixteen days after

Figure 4. Case 4. Choledochodochostomy.

Figure 6. Case 6. Choledochodochotomy.

surgery and readmitted three months later for removal of the T-tube. He has remained asymptomatic twelve years after surgery.

Case 5: A 68 year old white male had suffered a gastrointestinal hemorrhage in 1953. A diagnosis of prepyloric ulcer was made at that time. Five years later the patient had a subtotal gastrectomy at another hospital. During this procedure sutures were required to control bleeding from the gastroduodenal artery.

Five months later the patient was readmitted to the same hospital because of jaundice. A cholecystojejunostomy, Roux-en-Y, was performed. The jaundice was relieved for two weeks but gradually recurred. He was then transferred to our hospital for evaluation.

Upon exploration a Roux-en-Y cholecystojejunostomy was found. The gall bladder was markedly distended and there appeared to be no communication between the lumen of the gall bladder and the jejunum. The common bile duct was dilated to 1.5 cm and its wall was thickened. Complete obstruction of the common duct was encountered at a point just proximal to the junction with a sizeable pancreatic duct within the substance of the pancreas.

The head of the pancreas was dissected free and reflected medially. The common duct was divided just above the stricture and ligated. An end-to-side choledochoduodenostomy was completed over a #18 T-tube. The T-tube was brought out through an incision in the common duct above the anastomosis. The gall bladder was removed and the part of the jejunum which had been previously utilized for the cholecystojejunostomy was resected. Gastrointestinal continuity was reestablished by means of a jejunojejunostomy. His postoperative course was uncomplicated and he was discharged on the nineteenth postoperative day. T-tube cholangiogram revealed free flow of dye into the duodenum (Figure 5).

The patient was readmitted three months later at which time he had

Figure 5. Case 5. Choledochoduodenostomy.

gained thirty pounds. The T-tube was removed and the patient discharged. He has remained well for the past thirteen years.

Case 6: A 61 year old white woman had a cholecystectomy performed for a gangrenous gall bladder in another hospital. At that time hemorrhage from a torn hepatic artery was controlled by hemostats and the wound was left open. Drainage continued from the operative site for eleven weeks; it then stopped and the wound healed. Four months after surgery she experienced nausea and commenced vomiting. This was followed by periumbilical pain and jaundice. Eight months after the original procedure she was reoperated upon and a stricture in the common duct excised. The common duct was reconstructed over a T-tube. Although a T-tube cholangiogram failed to reveal the hepatic radicals and there was no bile drainage from the T-tube, her jaundice cleared and she was discharged.

The patient was admitted to our hospital two years later with her original T-tube in place. She was still experiencing intermittent bouts of nausea, jaundice, chills and fever. T-tube cholangiogram was performed which failed to reveal the hepatic radicals.

The patient was explored and considerable fibrosis was encountered in the area of portal triad. The common duct was obliterated as far

(Continued on page 54)

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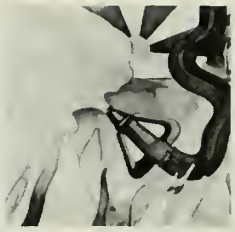

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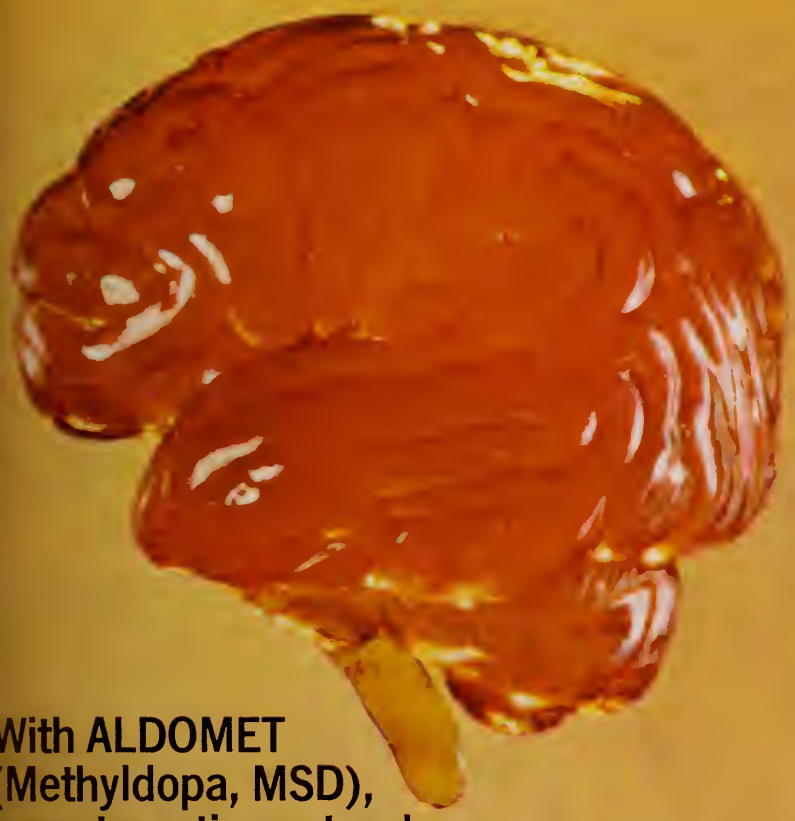

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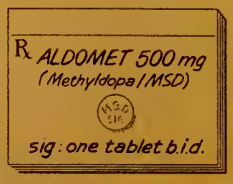

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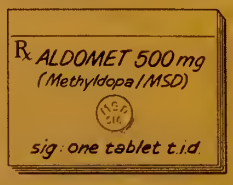

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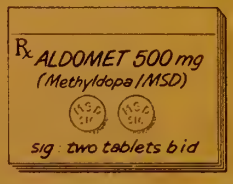

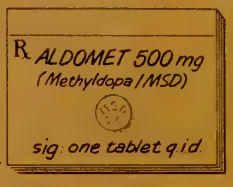

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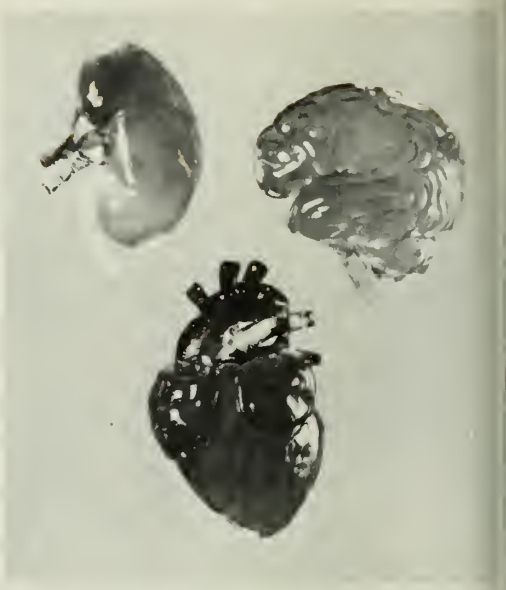

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

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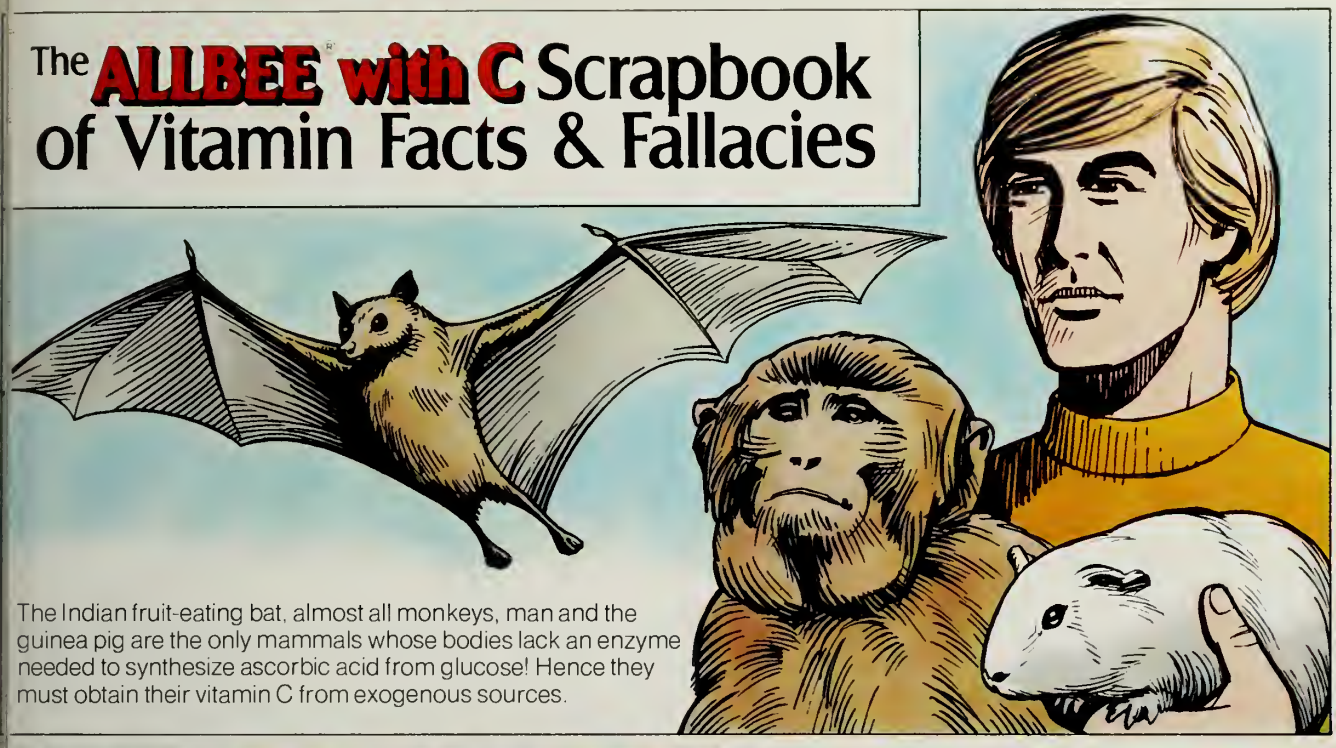
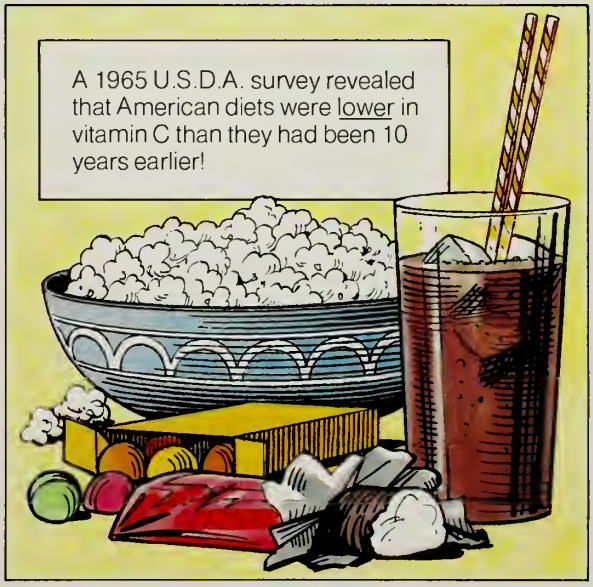


The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.

De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food." The disease he described was probably scurvy.



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Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur at higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients.

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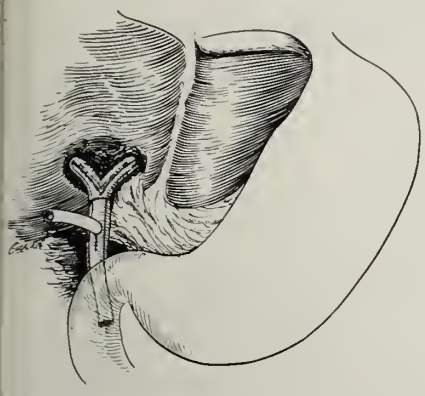

Figure 9. Choledochodochotomy.

#5-0 catgut. Number 3-0 silk sutures buttress the serosa to the capsule of the liver removing tension and preventing bile leakage (Figure 7).

A choledochoduodenostomy (Figure 8) was performed in one case. This procedure is used when the distal end of the common duct is not available for repair. As in the other procedures, a T-tube passed through the wall of the duodenum and extending into the common duct is used for support of the anastomosis. The technique for choledochodochostomy (Figure 9) and extrahepatic choledochojejunostomy (Figure 10) are also shown.

Ninety-eight percent of all common duct strictures are due to operative trauma.[4] If injury to the biliary tract is recognized at the time of operation, immediate surgical repair should be undertaken. Unfortunately, the majority of these cases are not recognized until jaundice or a biliary fistula ensues in the postoperative period. Since these cases usually show progressive impairment of liver function, delay in definitive surgical repair directly affects prognosis. Painless jaundice may develop two to three months after operation. The differential diagnosis of the jaundice is complicated since all of the patients have received injections or blood transfusions during surgery and homologous serum hepatitis must be ruled out. Both bile and urobilinogen may be found in the urine of a jaundiced patient who has incomplete obstruction due to a stricture of the common bile duct. In such cases, a diagnosis of hepatitis might be considered to the exclusion of the real cause. After prolonged obstruction of the extrahepatic bile ducts, hepatic function may be so impaired as to give laboratory results compatible with hepatitis. Increasing levels of serum bilirubin, alkaline phosphatase and bromsulphalein retention combined with alteration of the albumin/globulin ratio are definitive indications for surgical intervention. When jaundice or an external biliary fistula appear in the immediate postoperative period, operation should be undertaken.

Hanger[5] states that surgical visualization of the entire biliary tract is indicated in all cases of persisting or increasing jaundice accompanied by a negative thymol turbidity, cephalin flocculation and elevation of the alkaline phosphatase. Snell[6] enumerates the criteria that warrant surgical exploration of the jaundiced patient: (1) The reliable history of gall stones or colic; (2) Proven intermittent biliary obstruction with fever; (3) An associated biliary fistula with or without acholic stools; (4) Painless jaundice occurring within 6 months of cholecystectomy; (5) Proven complete and permanent biliary obstruction.

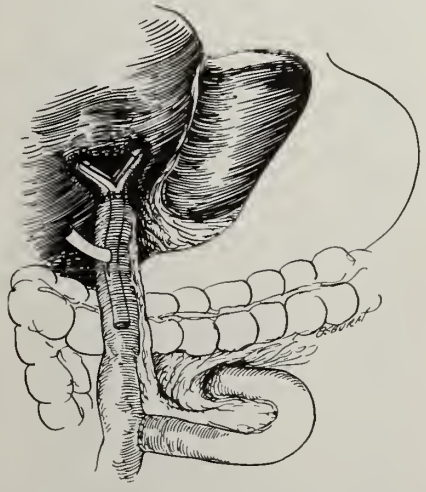

Figure 10. Extrahepatic choledochojejunostomy.

A most valuable adjunct in the diagnosis of common duct obstruction is percutaneous cholangiography.[7] In difficult diagnostic problems of postoperative jaundice this procedure not only portrays the status of the biliary tree, but accurately indicates the site of obstruction (Figure 11). Such information is invaluable to the surgeon in planning the surgical procedure to be undertaken.

Figure 11. Pericutaneous transhepatic cholangiogram.

It is our opinion that in a questionable case of jaundice the error of omission is greater than the error of commission. Any jaundiced patient who demonstrates prolonged obstruction of bile flow should be operated upon.

Summary

Six cases of extrahepatic biliary obstruction following surgical procedures are presented. Five of the patients had been subjected to one or more unsuccessful operative procedures for correction of their obstruction.

All six patients were successfully operated upon and relieved of their jaundice. The patients were followed from twelve to seventeen years and were free of symptoms.

Preoperative and postoperative evaluation, management and surgical technique in the treatment of patients with common bile duct injuries are discussed. □

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The placenta and placental transfer of drugs at term

EZZAT ABOULEISH, M.B., Ch.B, M.D.
Pittsburgh

The anesthesiologist's duty is not only to relieve the parturient's pain but also to support her physically and mentally to help in delivering a healthy baby. Therefore, I consider the proper understanding of the placenta, placental transfer of drugs and their effects on the fetus and newborn as essential not only for the anesthesiologist but also for the perinatologist and obstetrician.

Uteroplacental circulation

The placenta has two sides, maternal and fetal. The fetal and maternal circulations are separate and independent.

1. Maternal circulation of the placenta—Nutrients and oxygen are carried to the placenta by the uterine and ovarian blood vessels. At term, uterine blood flow is about 500-700 ml/minute. The majority of the uterine blood flow reaches the placenta (400-600 ml/minute) and only a small fraction is used by the uterine muscle.[17] Fifty ml/minute of the placental blood flow provides nutrition to the placental tissue, the remainder (350-550 ml/minute) reaches the intervillous space for metabolic and other exchanges with the fetal circulation (Table I).

Increased total blood volume and cardiac output during pregnancy permits increased uterine blood flow without compromising perfusion of other maternal organs, *i.e.*, liver and brain blood flow is not altered during pregnancy.

Blood reaches the placenta from the mother through uterine arterioles called spiral arterioles which open directly into the intervillous space (Figure 1). In the mature placenta there are about 60-100 arteriolar openings at the base of the placenta.[21] These arterioles act independently of each other so that not all are patent and discharging simultaneously.[131]

Blood leaves these arteriolar openings in fountain-like spurts, entering the intervillous space with a pressure of 60-70 torr (Table II). Pressure gradually drops as the blood passes through the intervillous space. Pressure in the intervillous space during uterine relaxation is about 10 torr and pressure in the uteroplacental veins is 5 torr. In contrast to other organ tissues in the body, there is no capillary network between these spiral arterioles and the corresponding veins. Blood flow in the intervillous space is affected by the number of patent arterioles, the pressure in these arterioles, the pattern and the frequency of the uterine contractions. The blood flow in the intervillous space is nonhomogenous and this is an important factor in delaying the equilibrium between maternal and fetal blood.

The capacity of the intervillous space is 250 ml. However, these villi have an extensive surface area to allow for the maternal-fetal exchanges. The total length of these villi is 30 miles and the surface area is 15 square meters.[147] After bathing the villi, the maternal blood returns to the pelvic veins via the uteroplacental venous sinuses accompanying the spiral arterioles and at the margin of the placenta by the marginal sinus.

During uterine contraction, blood flow through the uteroplacental circulation is impeded and outflow through the uteroplacental veins stops. A uterine contraction that raises the intrauterine pressure to 20 torr has minimal effect on the intervillous circulation. If this pressure rises to 30 torr, the intervillous circulation decreases by as much as 50 percent. Contractions leading to intrauterine pressure of 40 torr or more completely stop the intervillous perfusion and the fetus becomes isolated from his mother and must live on the reserve it has. If this reserve is compromised, or if the uterine contractions become tetanic, fetal asphyxia occurs. Fetal asphyxia can be potentiated by sedatives, narcotics and other depres-

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TABLE I

Distribution of Uterine Blood Flow at Full Term

Blood Flow	*ml/minute*
Total Uterine Flow	500 to 700
to myometrium	100
to placenta	400 to 600
to placental tissue	50
to intervillous space	350 to 550

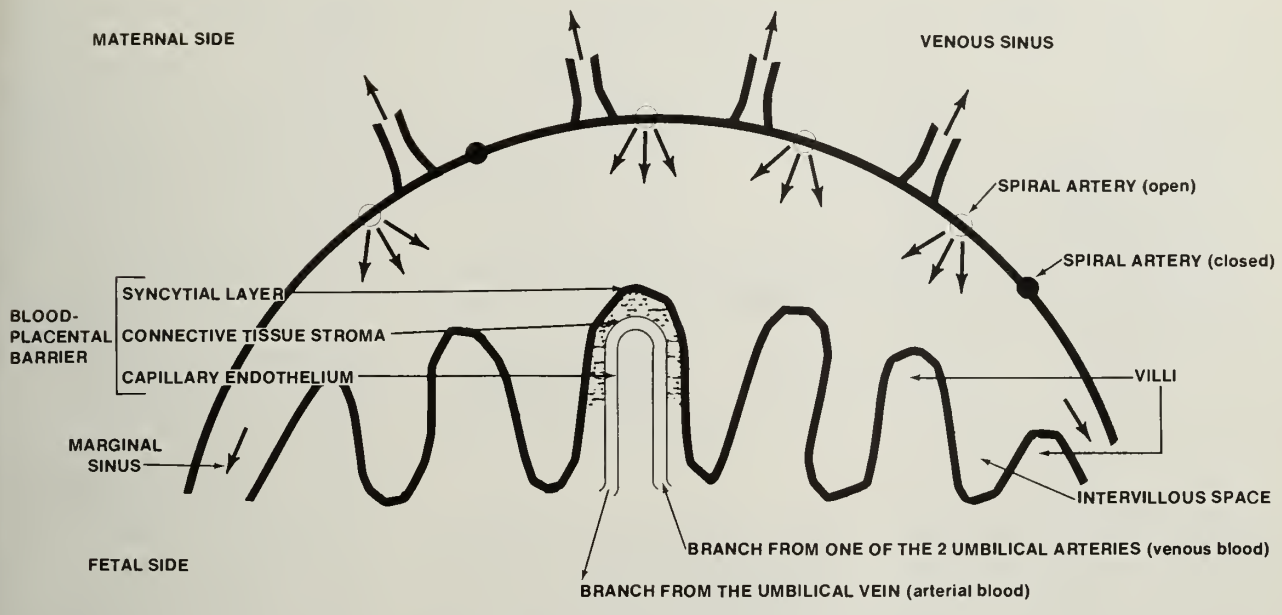


Fig. 1. THE MATURE UTEROPLACENTAL CIRCULATION (schematic)

sant drugs given to the mother for pain relief.

2. Fetal circulation of the Placenta—Within the umbilical cord there are three vessels. One umbilical vein carries arterial blood from the placenta to the inferior vena cava of the fetus and two umbilical arteries carry venous blood from the internal iliac arteries of the fetus to the placenta. Each villus has two vessels—one artery and one vein. The arterial branch divides into a network of capillaries which drain into the corresponding venule. There are no arteriovenous shunts in the villi which is a safety factor to allow oxygenation of blood as it passes through the capillary network before it reaches the venous side.[160]

Umbilical flow increases as the fetus grows and reaches a rate of 250 ml/minute at term. Therefore, the fetal-maternal blood flow ratio is 1:1.5.[17] In spite of this difference in the flow rate, the placental exchange is enhanced by the countercurrent flow of maternal and fetal blood.[104] This arrangement, used frequently in engineering, is highly efficient in establishing chemical equilibrium between the two bloodstreams and exists in sheep and rabbits.

In a primate placenta, a counterflow pattern is not seen, as formerly described by Barcroft and Barron.[10,160] Fetal blood flow makes a complete circle in each villus. Maternal blood flow, on the other hand, starts arterial at the arteriolar orifices and venous at the outflow orifices and intermediate elsewhere in the intervillous space. Uneven distribution of maternal to fetal blood flow would increase the net transplacental difference in oxygen tension and drug concentrations in the same way as ventilation-perfusion inequality in the lung increase the alveolar-arterial pO_2 difference.[96]

TABLE II

Human Maternal and Fetal Blood Pressures

		torr
Maternal	Spiral Artery	70-80
	Intervillous Space	10
	Venous Sinuses	5
Fetal*	Umbilical Artery	68
	Umbilical Vein	28

**modified from Windle 1971*

Blood-placental barrier

The blood-placental barrier (B-PB) consists of those tissues separating fetal and maternal blood. At term this consists of three layers (Figure 1): (1) syncytial layer, (2) stroma of connective tissue, and (3) fetal capillary endothelium. It is about 2-6 microns in thickness.[174] Any substance in the maternal blood must cross this barrier before reaching the fetal blood and vice versa.

Transfer of drugs across the placenta

It was formerly believed that the placenta is a semipermeable membrane allowing water and crystalloids to pass through and preventing colloids and large molecules. This simple concept has been replaced by a more complex but still poorly understood one in which the placenta selectively controls the rate of transfer of a wide variety of materials.[116] For all practical purposes, the B-PB resembles the blood-brain barrier (BBB) and therefore factors affecting drug transfer are similar.

TABLE III

Factors Influencing Transfer of Drug Across the Placenta

Drug	*Maternal*	*Fetal*
1. lipid solubility 2. molecular size 3. degree of ionization 4. concentration gradient across the membrane 5. binding to plasma proteins and red cells 6. method of administration 7. drug interaction	1. elimination of drug from maternal circulation 2. nonhomogenicity of blood in intervillous space 3. separation of maternal from fetal circulation 4. uterine contractions 5. maternal blood volume 6. uteroplacental blood flow	1. fetal liver 2. progressive dilution of blood en route to fetal brain 3. extensive shunting in fetal circulation 4. immaturity of the brain 5. enzymatic systems 6. fetal plasma, red cells, and pH 7. compression of umbilical cord during delivery

It is now believed that any substance found in the maternal or fetal blood should be able to cross the placenta to some extent unless it is destroyed or altered during passage. However, a very low degree of permeability may slow the entry which renders a drug physiologically inactive and pharmacologically undetectable. The important questions are not only whether a substance does or does not pass the B-PB, but also the mechanism of transfer, the rate of transfer, the ultimate quantity of the substance transferred and the effect on the fetus and newborn.[51] For all practical purposes the drugs used in relation to obstetric anesthesia and analgesia cross the placental barrier almost by simple diffusion from the side of higher concentration to that of lesser concentration.

I. Influencing factors—This transfer to and ultimate distribution of drugs in the fetus depends on three factors (Table III): (A) factors inherent in the drug itself, (B) maternal factors, and (C) fetal factors.

A. Drug factors—The B-PB can be considered as a membrane made of lipoproteins with small pores and an electrically charged surface. Therefore, the rate of transfer of a drug will vary according to:

1. lipid solubility—Fat soluble substances as barbiturates can easily pass through the membrane.[114]

2. molecular size—A substance of a molecular weight less than 100, such as nitrous oxide, passes readily through the pores in spite of its fat insolubility. Substances of molecular size between 100 and 600 pass at a rate controlled by their size. Substances of a molecular size between 600 and 1,000 pass through the placental barrier at a rate controlled by their fat solubility and degree of ionization. Substances of a molecular size more than 1,000, such as dextrose, require a carrier system to pass through the barrier.

3. degree of ionization—Ions carrying the same charge of the placental membrane are repelled. On the other hand, substances carrying an opposite charge to the membrane will be held in the membrane. Hence, ionization makes passing more difficult since ionized particles and substances are transferred in their undissociated or nonionized form.[46] The dissociation constant of a substance (pKa) is the pH at which 50 percent of the substance is ionizable. Therefore, the closer the pKa of a substance to the pH of the maternal blood, the more it becomes ionized and subsequently less transferable across the membrane.

4. concentration gradient across the membrane—With high maternal concentration relative to that of the fetus, a drug will pass easily to the fetus. This is an important factor applying to volatile as well as to nonvolatile drugs.

5. binding of the drug to the plasma proteins and red cells—Macromolecules and, therefore, drugs bound to macromolecules, cross biological membranes only with difficulty. Therefore, the binding of drugs to the maternal plasma proteins constitutes an important factor controlling the transmission of the drug across the placenta.[46] An example is bupivacaine which has more binding capacity to the maternal plasma than other anilide drugs.[166] Less of the drug, therefore, is available for crossing to the fetus, which explains the lower ratio of umbilical to maternal level of bupivacaine compared with other anilide drugs.[167] For those drugs found in plasma, the proportion of free drug will be less at lower total plasma drug concentration.[167] This explains the results that with the use of higher maternal dose of the same drug not only the level of umbilical blood will be higher but also the umbilical to maternal blood level ratio is higher.

6. method of administration—When a drug is given intravenously, it is carried around the body in bolus for one or two circulations.[120] Therefore, the drug presents itself at the placental site in a highly concentrated form. This leads to a high pressure gradient across the placental membrane and increased transfer of the drug to the fetus. This is particularly important in nonlipid ionizable substances that pass across the B-PB with difficulty such as muscle relaxants.[163]

Slow intravenous injection of a drug into the mother decreases its transmission to the fetus and therefore adds to the safety of the infant.[95, 164] Also, the amount of any drug transferred to the fetus can be decreased by injecting it at the beginning of a uterine contraction. By the time the bolus of the drug goes through the maternal circulation into the uterine arteries, the uterine contraction would be at its peak and intervillous perfusion is arrested so that little or no drug can be transferred during this first

circulation time.[52]

Intramuscular injection produces a steady trickle in the maternal circulation. Therefore, the maternal blood level will not be as high as following the intravenous injection. Subsequently, the gradient across the placenta and the transmission of the drug to the fetus will be less following intramuscular injection than after intravenous injection of the same dose.

The pharmacokinetics of inhalation anesthetics, such as halothane, differ from intravenous anesthetics, such as thiopental, or local anesthetics, such as lidocaine. In contrast to the latter two agents, which are usually given by single or intermittent injections, inhalation anesthetics, such as halothane, are administered continuously to the mother. Therefore, the blood and tissue time concentration curves of halothane show a generally rising course[62] in contrast to the falling course encountered with thiopental[88] and lignocaine.[150]

7. drug interaction—This is an important factor which one should bear in mind, e.g., competition between different drugs for plasma binding sites or tissue binding sites may affect the course of transmission of these drugs to the fetus, and their toxicity.[65]

B. Maternal Factors

1. elimination of the drug from the maternal circulation—This is achieved by leaving the intravascular bed to the extravascular compartments and by excretion and/or metabolism. The elimination of a drug from the maternal blood will affect the balance across the placental membrane. If no elimination occurs, sooner or later equilibrium is reached between maternal and fetal blood and the levels of the drug will be equal in both mother and fetus. Also, the level in the umbilical vein will equal that in the umbilical artery. If elimination of the drug from the maternal circulation is faster than in the fetus, the maternal level will fall below the fetal level and the passage of the drug will be reversed. In such a case the drug level in the umbilical artery will be higher than in the umbilical vein, e.g., with diazepam.[141]

2. nonhomogenicity of the blood in the intervillous space—This factor delays the transmission of a drug to the fetus, e.g., for two to three minutes.

3. separation of the maternal from fetal circulation—Therefore, there is no instantaneous exchange between mother and fetus. Factors 2 and 3 are responsible for the delay in transmission of drugs, e.g., nitrous oxide and thiobarbital from mother to fetus.

4. uterine contractions—During active labor and delivery, each time the uterus contracts, the fetus is isolated from the mother and blood flow, as well as drug transmission stops.

5. maternal blood volume—In cases of hypovolemia, the same given dose of a drug will be less diluted and thus reaches a higher concentration in maternal blood. The pressure gradient across the placental membrane becomes higher allowing for more transmission of the drug to the fetus.

6. uteroplacental blood flow—This is equivalent to ventilation of the lung in reaching equilibrium of inhalation anesthetics. Hypoperfusion has a similar effect to hypoventilation, i.e., diminishing the transfer of drug and delaying equilibrium across the placental membrane.

C. Fetal factors

1. fetal liver—The exact amount of umbilical vein blood flow that perfuses the human fetal liver is still controversial.[9,19,40] It has been estimated that the amount that bypasses the liver through the ductus venosus is from one third to two thirds of placental venous return in the human fetus. Perfusion experiments in stillborn infants give similar results.[155] Therefore a good portion of any drug crossing the placenta is immediately brought to the liver.

In the human fetus the left lobe of the liver receives blood mostly from the umbilical vein while the right lobe is supplied mostly by blood from the portal vein.[68,135] This explains the results of Finster et. al.,[54] i.e., the concentration of thiopental in the left lobe of the human fetus is higher than the right lobe and both are higher than the maternal blood level. However, following repeated maternal injections of thiopental, the two lobes of the fetal liver contained almost equal concentrations of the drug. This is due to the prolonged exposure of the fetus to thiopental and its recirculation within the fetal body which produced nearly identical drug concentrations in all fetal vessels. The high thiopental uptake by the liver could be due not only to the pattern of fetal circulation but also the presence of two cytoplasmic protein fractions (Y and Z proteins) in the hepatic cells which appear to be important in the uptake of organic anions from the plasma.[93]

Therefore, the strategic position of the liver in the fetal circulation is important for extracting substantial amounts of the drugs entering the fetus and thus protecting the fetal brain.[55] This has been demonstrated with thiopental,[54] [82] bromide-halothane,[62] lidocaine,[53] and ^{14}C-cyclamate.[122] At all times the concentration of each drug in the liver was higher in the fetus than in the mother.

2. progressive dilution of blood en route to the fetal brain—Blood in the umbilical vein becomes diluted with blood from the gastrointestinal tract and lower limbs before it is shunted through the foramen ovale of the heart and then to the brain.[20] This dilution decreases the concentration of any drug that traversed the placenta.

3. extensive shunting in the fetal circulation—Fifty-seven percent of the combined cardiac output of the lamb fetus (and presumably a similar amount in the human) returns to the placenta without perfusing fetal tissues. This is due to extensive shunting via the foramen ovale and the ductus arteriosus. Hence the fetal tissues are not exposed to over

half of the absorbed quantity of the drug during each circulation.

4. immaturity of the brain of the fetus and young neonate—The brain of the fetus and newborn has been found to be deficient in myelin.[160] This may explain the fact that newborns are more sensitive to the action of depressant drugs than are adults of the same species.[117]

5. enzymatic systems—Neonates are known to have poorly developed enzymatic systems. Therefore, some drugs, e.g., barbiturates and anilide type local anesthetics, such as lidocaine and mepivacaine, are not readily metabolized by the newborn.

6. fetal plasma, red cells and pH—These are different in the fetus than in the mother. Therefore, the extent of binding and ionization will be different on either side of the placental membrane.[167] For example, there is a lower binding of amide type local anesthetics in umbilical than in maternal plasma. On the other hand, there is a possibility of greater binding of diazepam to fetal plasma proteins and fetal red cells. These differences in binding properties across the placenta will affect the gradient of the free unbound portion of the drug and, therefore, the direction and rate of its transfer.

7. compression of the umbilical cord during delivery—Compression of the umbilical cord occurs to some extent in about one third of vaginal deliveries.[82] This cord compression interferes with the transmission of drugs to or from the fetus.[101]

The fetal factors 1, 2, and 3 are at least temporary protective factors tending to decrease the concentration of drug reaching the fetal brain. However, with time the umbilical artery concentration approaches the umbilical vein concentration of the drug and the quantity of the drug reaching the brain is high. Subsequently, continued redistribution of the drug within the fetus results in diminution in drug concentration in the fetal brain. Meanwhile, with a single dose, drug levels in maternal blood continue to decline, tending to establish a reverse gradient from the fetus outward. Thus, with time both these factors contribute to lessening the effect of a bolus of a drug administered intravenously to the mother. This explains the maximum fetal depression between three and seven minutes after intravenous injection of 8 mg/kg thiobarbiturate to the mother.[88]

Before three minutes delay in transmission to the fetus, the fetal liver uptake, the progressive dilution and shunting in the fetus tend to protect the fetal brain. After seven minutes, the progressive redistribution in the fetus and the fall in the maternal blood concentration tend to lower the brain level of thiobarbiturate, subsequently diminishing the fetal depression.[88] On the other hand, if the drug is repeatedly administered, the maternal blood level is sustained at a high level and there becomes a tendency to "load" the fetus despite the protective processes already mentioned.

II. Transfer of special drugs related to obstetric anesthesia and analgesia

A. Barbiturates—Barbiturates consist of highly lipid-soluble molecules which pass freely through the lipid membranes such as the blood-brain, blood-placental and other blood-tissue barriers. The slow acting barbiturates, such as phenobarbital (Luminal), and the intermediate acting barbiturates, such as amobarbital (Amytal), have been shown to traverse the B-PB rapidly and achieve equilibrium in 5-20 minutes. The fast acting barbiturates, such as pentobarbital (Nembutal) and secobarbital (Seconal), can be detected in fetal blood within one minute of intravenous administration to the mother and equilibrium is established between the mother and infant within three to five minutes.

The initial studies of the placental transfer of the ultrafast acting barbiturates, such as thiopental sodium (Pentothal), suggested that only minute amounts of the drug were found in the newborn infant during the first five to seven minutes and equilibrium between maternal and fetal blood was reached only after ten to twelve minutes.[74]

On the basis of these data, misconception developed among clinicians that thiopental could be given without affecting the baby if delivery was achieved within eight minutes. However, subsequent studies showed that the drug passes the membrane within 45 seconds, achieving the highest concentration in the umbilical vein blood within two to three minutes after injection, following which both maternal and fetal plasma concentrations fall exponentially.[35,36,88] Since the metabolism of thiopental is slow, 10-15 percent per hour, the fall in plasma concentration is mainly due to redistribution.

In obstetrics, thiobarbiturate in a single dose of 4 mg/kg is associated with the delivery of neonates of good Apgar score (7 or more) in 90.9 percent of cases. With a large dose (8 mg/kg) marked neonatal depression can occur as only 57.1 percent of newborns had good Apgar scores. This is due to the associated high maternal and fetal blood levels. These neonates remain drowsy for many hours after delivery.[169] Repeated administration of small increments following the initial dose of thiobarbiturate has an intermediate effect. *Therefore, in obstetrics, when a thiobarbiturate is to be used, the recommended dose is 4 mg/kg administered once.* Thiamylal and thiopental, both thiobarbiturates, have the same effect on the fetus.[88]

B. Propanidid—Propanidid is a nonbarbiturate intravenous anesthetic. It is rapidly hydrolyzed in the body by esterases to pharmacologically inert products. Both maternal and fetal blood levels of propanidid are negligible within three to four minutes of intravenous injection. Cholinesterase is present in large quantities in placental tissues and could play a part in breaking down propanidid, thus minimizing the concentration reaching the fetus.[34] This can explain the lower incidence of neonatal depression following pro-

panidid induction (500 mg) versus thiopental (250 mg) for elective cesarean section.[8,23] However, the high incidence of maternal awareness[23,43] and postoperative nausea and vomiting[43] are important disadvantages of propanidid.

In the author's opinion, if a thiobarbiturate dose is kept at or below 4 mg/kg, propanidid does not offer a practical advantage over the former drug.

C. Narcotics and their antagonists

1. narcotics—There is extensive evidence in the literature that narcotics cross the B-PB.[3,17,117,149] This was suspected as early as 1885.[127] Narcotics are capable of fetal and neonatal depression. The fetal depression can be shown by onset of bradycardia (an average drop of 17 beats per minute) following maternal administration of morphine.[67] The neonatal depression is evidenced by respiratory depression, myosis, absence of reflexes and hypotonia. It is advisable to avoid narcotic administration to the mother when delivery is expected between one and four hours following their intramuscular administration. It is our policy to use narcotics only in the first half of the first stage. If delivery unexpectedly occurs rapidly, naloxone (Narcan) can be injected into the umbilical vein after delivery. Synthetic narcotics are safer for the fetus because they do not traverse the fetal brain-barrier as easily as morphine.[98] Two of the commonly used narcotics in obstetrics, namely, meperidine and pentazocine, will be discussed in more detail.

(a) meperidine—Meperidine rapidly crosses the B-PB.[38] After intravenous administration to the mother, the umbilical vein level reaches 70 percent of the maternal level in 30 seconds. This is then maintained for five to ten minutes to be followed by a rapid decay.[19] Meperidine concentration is higher in the umbilical vein than in the umbilical artery for the first three to five minutes, but thereafter the levels virtually equalize. The maternal metabolites of meperidine also cross the placenta. Most studies have shown no correlation of the Apgar scores and the clinical condition of the infant with the level of meperidine in the plasma. But there is always the possibility of neonatal depression following meperidine administration to the mother,[22] particularly when it is given shortly before delivery. With the use of continuous regional analgesia, the need for narcotics and their subsequent fetal depression is diminished.

(b) pentazocine (Talwin)—Pentazocine, a member of the benzomorphan series, is a potent analgesic. Forty milligrams of pentazocine has an equal analgesic effect to 100 milligrams of meperidine.[108] It has a low abuse liability and, therefore, it is not subject to narcotic control. It has less emetic effect than meperidine.[112] As regards its effect on the fetus, animal experiments have demonstrated no teratogenic or embryotoxic effect.[173] However, the safety of its use during pregnancy is still uncertain.

During labor, it proved to be a satisfactory analgesic drug[45] crossing the placenta to a lesser degree than meperidine.[14] It causes no significant change in fetal heart rate.[1,50,105,108] Following its administration to the mother, the incidence of neonatal depression is not significant. Moore and Hunter[108] found that following pentazocine administration to mothers within four hours of delivery, 2.6 percent of the neonates were depressed compared with 6.8 percent following meperidine. This was in agreement with the work of Gonzales Munoz.[63] However, Mowat[112] found no significant difference between the two drugs as regards neonatal depression.

2. premixed solutions of narcotics and narcotic antagonists—It is claimed that administration of such a mixture can produce analgesia to the mother without fetal or maternal depression. Unfortunately, these claims have not been borne out by careful clinical trials. On the contrary, the premixed solutions have less analgesia and more side effects in the mother and fetus and they are not advised.[19]

3. narcotic antagonists—Narcotic antagonists, such as nalorphine, levallorphan, and naloxone (Narcan), also have been found to cross the placental membrane rapidly. This is not unexpected since they represent only slight modification in the molecular structure of narcotics. The best available narcotic antagonist is naloxone. This is because it is effective and will not depress the newborn if the cause of depression is other than narcotics. Also, naloxone does not cause respiratory depression even with overdosage. It can be administered to the mother intravenously (0.01 to 0.02 mg/kg) 10-15 minutes before delivery, or injected into the umbilical vein immediately after delivery when its action is apparent in 30-90 seconds, or injected intramuscularly to the newborn when the onset of action occurs in 3-5 minutes.

The umbilical vein route is the route of choice if feasible. The dose is 0.02 mg/kg in 2 ml saline. Wait for one minute after injection, then clamp the cord and separate the fetus. In this way the narcotic is antagonized in the fetus without depriving the mother of the analgesic and sedative effects of the narcotic. The fetal depression that follows neuroleptanalgesia in obstetrics can be corrected in the same way.

D. Tranquilizers—Chlorpromazine (Thorazine), promethazine (Phenergan), and promazine (Sparine) can be found in the umbilical vein blood within 1.5 to 2 minutes on intravenous administration to the mother with a maximum fetal concentration occurring during the ensuing two to three minutes.[37] Most studies have shown that the fetal blood concentration is lower than that in the maternal blood. A significantly greater proportion of these drugs given to the mother is passed to the fetus after intravenous than after intramuscular administration.

1. diazepam (Valium)—Diazepam is a drug recently used in obstetrics for its anticonvulsing, muscle re-

laxing, amnesic and tranquilizing actions. It was also found to potentiate the analgesic effect of meperidine.[57] It rapidly crosses the placenta to the fetus. After intravenous administration to the mother during labor, it appears within ten minutes in the fetal blood.[141] After intramuscular administration to the mother, diazepam reaches its peak in the maternal blood in 30 minutes and in the fetal blood in 60 minutes.[80] The level of diazepam in the fetal blood is at least equal,[41] if not higher, than in the maternal blood.[141] This can be due to more binding of diazepam to fetal blood cells and plasma proteins.[80] Diazepam concentrates in the fetal liver which metabolizes the drug to a much slower rate than the adult liver(1:10).[80]

As regards the effects of diazepam on the fetus, Flowers, et. al.,[57] found that a significantly higher percentage of infants whose mothers had received diazepam were depressed compared with those whose mothers had received no diazepam. The depressed neonates were characteristically hypotonic. The depressant effect of diazepam on the fetus was also manifested by loss of the normal beat-to-beat variation and periodic oscillations in the fetal heart rate.[141] This followed a relatively large intravenous dose (20 mg) to mothers in labor. This cardiac action of diazepam can be due to sleepiness of the fetus, to the depressant effect of the drug on the cardiac reflex centers in the brain, or both.[13] However, this effect on the fetal heart rate is temporary and not associated with fetal acidosis.

In our experience, small I.V. doses of diazepam (2.5 mg at a time to a maximum of 10 mg) usually have no fetal side effects during labor and delivery. One or two of these increment doses are quite helpful for epidural or subarachnoid block, causing sedation and relaxation of the mother during the procedure. Doses of 10 mg are rarely exceeded in obstetrics, except as a treatment of convulsions.

2. hydroxyzine hydrochloride (Vistaril)—This is a tranquilizer that has been used in obstetrics without clinical ill effects on the fetus.[11,15,81] However, until now no data are available regarding its transmission to the fetus.

E. Muscle relaxants—At normal pH range, muscle relaxants are highly ionized and possess a low degree of fat solubility. Because of these properties, they pass the blood-brain barrier and the blood-placental barrier with great difficulty. Usual clinical doses have no demonstrable effect on the newborn. If massive doses of these drugs (10 times or more than the therapeutic dose) are injected into the maternal circulation, the gradient across the placenta becomes so high that the relaxant in appreciable amounts is detected in the fetal blood and can have clinical effects on the newborn. Some of the commonly used muscle relaxants are:

1. curare—The transplacental transmission of curare has interested many investigators for almost a century. Animal experiments have been widely performed since 1885.[127] Curare has been one of the few drugs whose transplacental transmission was tested from mother to fetus and vice versa. As regards its transmission from mother to fetus in experimental animals, Preyer[127] and Harroun[70] found no harmful effects on the fetus, provided the mother was well ventilated. Pittinger,[124] using dogs, injected curare in the uterine artery of the mother in huge amounts. This resulted in partially curarized pups. As regards transmission from fetus to mother, Preyer[127] and Buller[24] found that the drug can pass the placental barrier and cause maternal paralysis if injected in the fetal blood in massive doses.

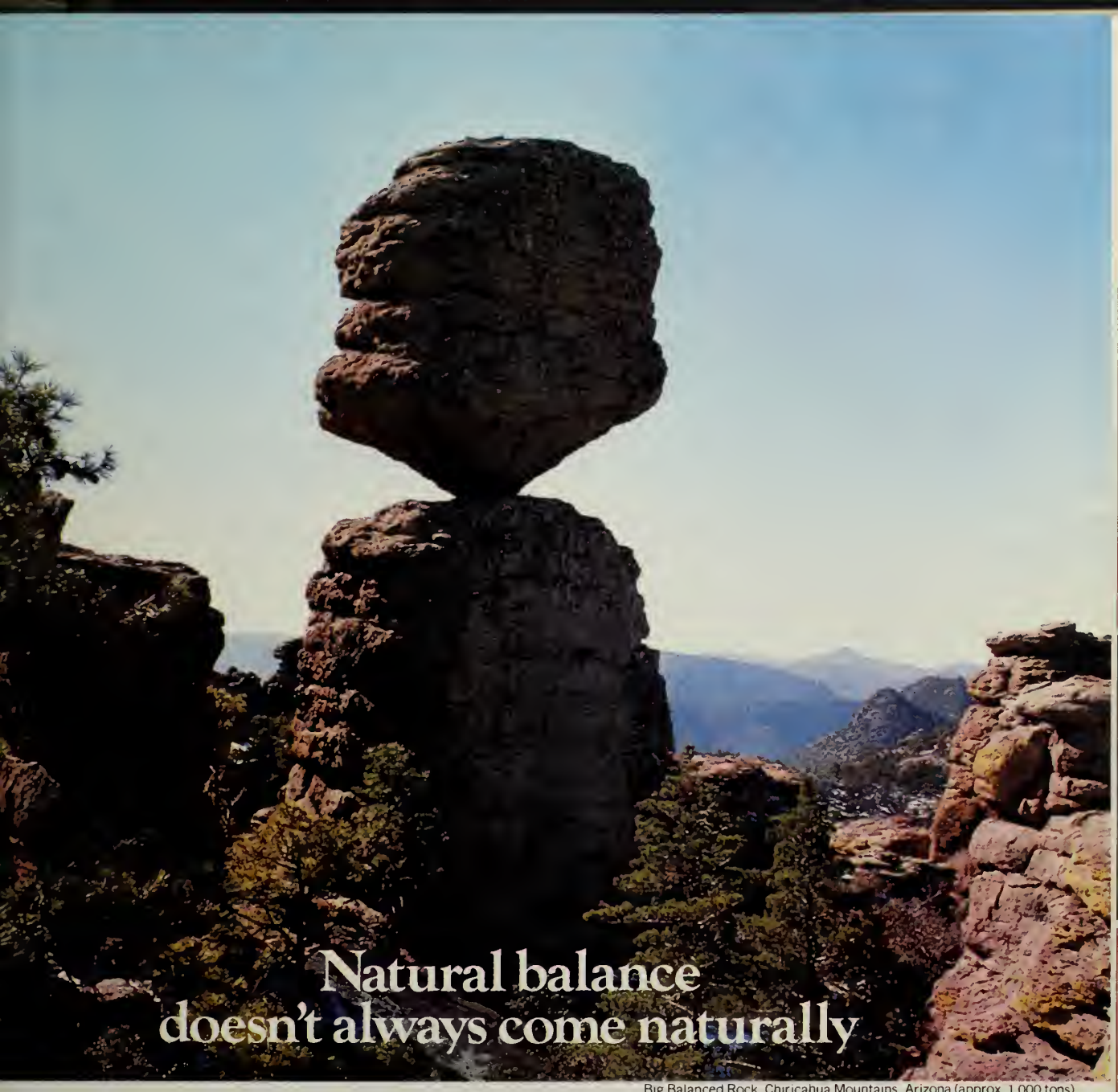
Quantitative estimations of curare in the fetus after maternal administration have been performed.[29,36,123] The results indicate that after intravenous administration of the drug to the mother, it is transmitted to the fetus but in such minute traces that it has no harmful effect on the fetus or newborn. These laboratory results were in accordance with the safe clinical use of the drug in obstetrics.[29,36,66,123,170,171]

The transmission of curare to and its distribution in the human fetus during the first trimester was recently studied using ^{14}C-dimethyltubocurarine.[86] The results show that ^{14}C-dimethyltubocurarine concentration in fetal plasma was about one tenth of the maternal plasma concentration. ^{14}C-dimethyltubocurarine is transmitted to the fetus mainly in the intact form. Only a small part of its metabolites passes the placental barrier. Of the fetal tissues, the lungs and the liver showed the highest concentration. As expected, a markedly lower concentration was found in the brain tissue. The fetal brain concentration was about one tenth per gram the fetal plasma concentration per ml. Since the fetal plasma concentration is about one tenth the maternal plasma concentration, the similarity between the blood-brain barrier and the blood-placental barrier becomes evident.

In summary, curare is safe to use in obstetric anesthesia in a dose of 0.5 mg/kg provided the mother is adequately ventilated.

2. gallamine triethiodide (Flaxedil)—Schwarz[142] determined the iodide concentration in the fetal blood at the time of delivery after maternal administration of gallamine. He found that six to nine minutes after the injection of 80 mg, significant increases in the concentration of iodide occurred in the neonate. Schwarz interpreted this as evidence that gallamine had crossed the placenta. That is why many anesthesiologists refrain from using it. However, since gallamine triethiodide is a quaternary ammonium salt, it is completely ionized in aqueous solution and consequently the transport of the triethylgallamine ion and the iodide ions through the body membranes will be independent of each other. Hence, iodide concentrations give no indication of triethylgallamine concentrations. This explains the discrepancy between its clinical effects on the newborn and the laboratory findings. Depending on the

(Continued on page 68)



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CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

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Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

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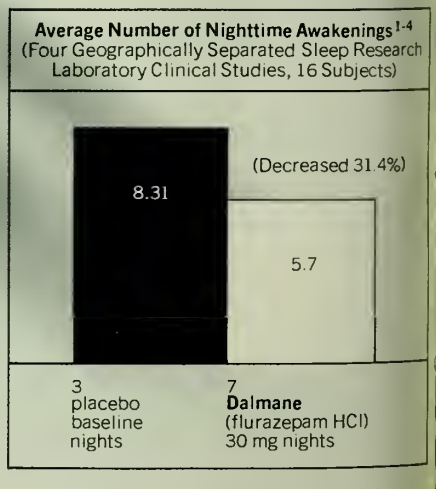

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Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

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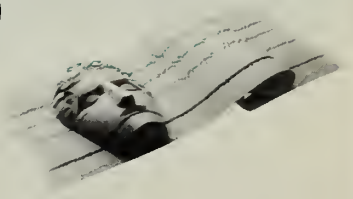

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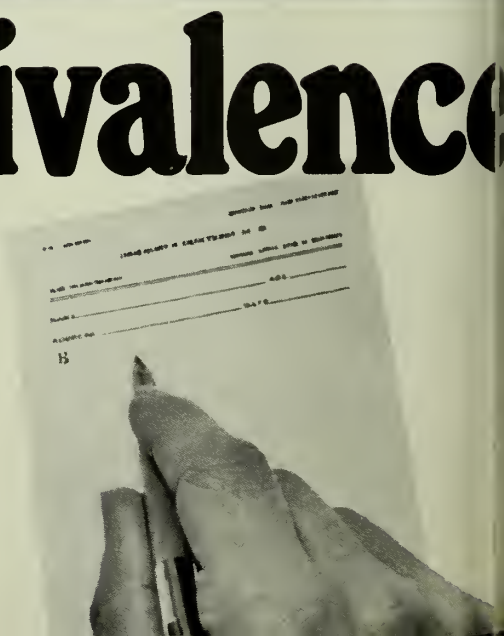

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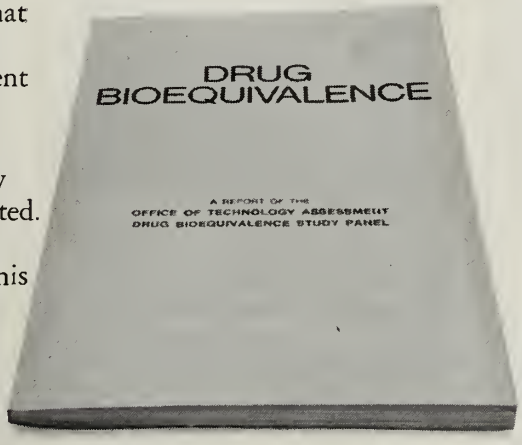
Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or

(c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A

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*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

protecting the integrity of your prescription

Placental transfer

(Continued from page 62)

clinical effects on the fetus, Pittinger and Morris[125] found gallamine to be less transmissible than d-tubocurarine across the dog placenta. In humans, Crawford and Gardiner[36] found that, although gallamine in appreciable concentration was detected in the fetal cord blood, none of the infants were depressed. On clinical results, Thomas and Gibson[162] and Bakhoum and Aboul-Eish,[7] found gallamine safe in obstetrics. Therefore, further studies are required to clarify the placental transmission of gallamine and its effect on the fetus and newborn.

3. succinylcholine—The transfer of succinylcholine has been examined by Moya[113] and Kvisselgaard,[115] who found that the drug did not pass from mother to fetus following normal clinical doses, but that low fetal plasma concentration could be detected following a 300 mg dose to the mother. Since the usual dose of succinylcholine is 1mg/kg, this dose (300 mg as a bolus) is several times the therapeutic dose. However, recently using ^{14}C succinyldicholine in monkeys, Drábková, et. al.,[44] found that succinylcholine in doses of 2-3 mg/kg, and in repeated doses of 1.2 mg/kg injected intravenously, is rapidly transmitted to the fetus. However, the fetal level of succinylcholine slightly affected electromyograph with no depressant effect on fetal respiration. Succinylcholine has been extensively used as a muscle relaxant in obstetrics, particularly for cesarean section. It proved to be satisfactory and safe.

4. alcuronium—Recently alcuronium has been introduced as a safe nondepolarizing muscle relaxant and has been used with favorable results in obstetrics.[33,143,159,163] Like most muscle relaxants, it crosses the placenta to the fetus in minute quantities without ill effects on the newborn.[164] When 10-15 mg was injected slowly intravenously over a period of two to six minutes, it did not cross the placenta. This signifies the importance of the rate of injection as a factor for drug transmission to the fetus.

5. pancuronium—No evidence is available in man but animal experiments suggest that in normal dosage it does not cross the placental barrier.[175] It has been used in cesarean section without ill effect on the newborn.[19,92] The dose is usually 0.1 mg/kg. Pancuronium has certain advantages over curare, e.g., pancuronium is devoid of hypotension and histamine release. It is rapidly gaining an eminent place as a muscle relaxant in obstetrics.[118]

F. Belladonna Drugs—Belladonna drugs pass the blood-placental barrier. One mg of atropine intravenously administered to the mother produces fetal tachycardia[73] and mydriasis.[127] Administration of atropine to the mother can prevent fetal bradycardia that occurs with maternal hemorrhage but will not correct the associated fetal hypoxia.[16] Scopolamine administered to the mother has not only the potential depressant effect on the fetus,[56] but also frequently causes agitation of the parturient. Scopalamine was frequently used for its amnesic effect. Its combination with morphine, the so-called "Twilight sleep," is only mentioned to be condemned and has no place in modern obstetrics because of fetal depression, maternal depression, agitation and inadequacy of pain relief.

G. Catecholamines—Rapid transfer of the catecholamines, norepinephrine and isoproterenol from the maternal to the fetal side of the placenta has been demonstrated in vitro in the human placenta and in vivo in the guinea pig.[111] There are certain clinical implications of these findings. Isoproterenol is widely employed in the treatment of asthma in both pregnant and nonpregnant patients. While deleterious effects on the fetus do not, to date, appear to have been reported, these findings should alert obstetricians to possible consequences of this powerful drug gaining access to the fetal circulation. It is claimed that the use of epinephrine and norepinephrine in concentrations of 1/200,000 or less in the epidural space is not harmful to the fetus and even advantageous by lowering the maternal blood level of the local anesthetic.[28,59]

H. Magnesium—Parenterally administered magnesium sulfate has been extensively used, at least in the United States, as an integral part of treatment of toxemias of pregnancy. Therefore, the transplacental transmission of this drug and its effect on the fetus are important. Magnesium sulfate readily crosses the blood-placental barrier and the fetal blood level rapidly reaches that of the mother.[129] The effect of Mg^{++}on the fetus is still debatable. Hutchinson, et. al., [78] and Stone, et. al.,[158] found no evidence of adverse action of Mg^{++}on the infant. On the other hand, Lipsitz and English[94] found that Mg^{++}can cause fetal depression. Their findings showed that the clinical manifestations in the newborn with hypermagnesemia were similar to those in the adult, namely, hypotonia, hyporeflexia, hypotension, and respiratory depression. These symptoms should be looked for in newborns delivered from mothers that have had magnesium sulfate prior to delivery. The effects of excess magnesium or other CNS depressants on the already compromised newborn of a toxemic mother can be serious. Therefore, it is advisable to have the personnel and equipment ready for neonatal resuscitation whenever a toxemic mother is in labor.

I. Local Anesthetics—Local anesthetic drugs cross the placenta from mother to fetus[110 150] and from fetus to mother.[109]

When these drugs are administered for regional analgesia in obstetrics, they are rapidly absorbed into maternal blood and transmitted across the placenta.[6,53,64,110,150] Except in the case of spinal analgesia, relatively large doses are necessary and these occasionally result in high blood level in the fetus and neonatal depression.[6,110]

In discussing transmission of local anesthetics across the placental membrane and their effect and distribution in the fetus, two

angles of the subject have to be considered: (1) the drug used and (2) the regional technique applied.

1. drug used

(a) esterase type—Esterase type drugs, such as procaine, chlorprocaine and tetracaine, are broken down by esterases in maternal and fetal plasma and placenta. Moreover, procaine is highly ionizable at normal maternal pH. Therefore, it will not cross the placenta readily.[175] This explains the excellent condition of the neonates delivered under combined continuous epidural and caudal techniques, using 4 percent procaine as the main anesthetic.[28]

(b) anilide type—These drugs have different pKa values, lipid solubility and some have vasoconstrictor or vasodilator effect. Therefore, if administered epidurally in equal doses, they attain different blood values, the ratio of mepivacaine to lidocaine to bupivacaine is 3:2:1.[133] For the same reasons they cross the placental barrier to a different extent and the fetal-maternal ratio varies with the anesthetic drug. The umbilical venous plasma to maternal venous plasma is on the average 30 percent for bupivacaine,[167] 55 percent for lidocaine,[134] and 70 percent for mepivacaine.[110]

In contrast to findings with lidocaine, mepivacaine and bupivacaine, data obtained from a study involving epidural administration of prilocaine suggested net reverse transfer of this drug across the placenta in about 50 minutes after administration. This is evidenced by concentration ratios of the drug in the umbilical artery to the drug in the umbilical vein greater than unity.[126] Umbilical levels of prilocaine slightly in excess of corresponding maternal levels have also been reported.[126,71] The fact that prilocaine is less bound to maternal plasma than other anilide drugs[49] may help to explain these findings.

In epidural analgesia, epinephrine added to the local anesthetic lowers the maternal level and therefore by decreasing the threshold across the placental membrane, decreases the level in the fetus. This is evident with local anesthetics, such as lidocaine.[59] However, with bupivacaine, the addition of epinephrine did not significantly alter the fetal blood level of the local anesthetic.[133] This is probably due to the initially low level of maternal bupivacaine, little effect of epinephrine on the maternal level, the inherent vasoconstrictor effect of bupivacaine and the change of the pH of the solution by the addition of epinephrine. Therefore, when bupivacaine is used for epidural analgesia, the addition of epinephrine does not add to the fetal protection and can even prolong the course of labor,[69] or cause hypotension;[168] both are undesirable. Moreover, epinephrine may reduce uterine blood flow either by redistribution of cardiac output or by direct action on uterine blood vessels. Therefore, with use of bupivacaine, we stopped adding epinephrine to the local anesthetic in obstetrics.

In summary of the anilide-type agents, the drug of choice for epidural analgesia is bupivacaine (Marcaine) because it not only has the longest analgesic action but it also reaches the lowest maternal level and it is the least transmitted to the fetus. This explains the finding that the use of bupivacaine for both single dose and continuous epidural analgesia, as well as single dose paracervical block, was safe for mother, fetus and newborn.[79] Neonatal depression was rare, mostly associated with asphyxial factors independent of anesthesia and had no correlation with bupivacaine fetal blood levels. The least recommended drug for regional anesthesia is prilocaine because of its high fetal transmission as well as causing methemoglobinemia of the mother and fetus.[5,126]

2. regional technique used

(a) spinal—It is the technique using the lowest dosage. Therefore, there is no evidence that fetal depression can be due to the local anesthetic per se when used for the subarachnoid block.

(b) lumbar epidural and caudal—It is widely believed that little of the local anesthetic agent administered into the epidural space of the mother reaches the fetus.[59,150,167] The infants are usually vigorous at birth, provided there have been no maternal complications, e.g., maternal hypotension or convulsions. However, transient mild fetal distress may follow continuous epidural analgesia[71] as evidence by loss of the normal variability of the fetal heart rate. Printz[128] also showed transient unexplained fetal deceleration with continuous epidural analgesia in 11 percent of his cases. However, this fetal deceleration was not related to epidural anesthesia and they were of the same pattern seen without anesthesia.

(c) paracervical block—Paracervical block is the only regional analgesic technique in obstetrics that exposes the fetus to the risk of overdosage. This is because of the extreme rapidity with which the local anesthetic drugs are absorbed from the broad ligament.[64] Moreover, when the local anesthetic drug is injected close to the uterine arteries, it can reach the placenta directly by rapidly diffusing across the arterial walls.[156]

This explains the finding that the ratio of the concentration of bupivacaine in the umbilical venous blood was significantly higher after paracervical block (60 percent) than after epidural block (30 percent).[79] Moreover, other local anesthetics can reach a higher level in fetal blood than in maternal blood following paracervical block.[6]

This high level of the local anesthetic in the fetal blood leads to myocardial depression, bradycardia and fetal acidosis.[6,60,64,136,148,161] Furthermore, a number of cases of perinatal deaths have been ascribed to local anesthetic intoxication of the fetus following paracervical block.[47,119,138,161]

To minimize the dangers of paracervical block, certain precautions should be followed.

1. Paracervical block should not be used more than once.
2. Minimal anesthetic drug should be injected, e.g., 5 ml of 1 percent lidocaine, 1 percent mepivacaine, or 0.25 percent bupivacaine on each side. Even

a smaller volume can be used by jet injection.[61,72]

3. No epinephrine is used.[87]
4. The chosen site of injection is preferably more posterior to be further away from the uterine blood vessels.[28]
5. The fetal heart rate should be continuously monitored for the next 30 minutes using either external or internal monitors.[161]
6. If fetal bradycardia occurs, the mother should lie on her left side with oxygen administration.
7. The depressant effect of paracervical block on the fetus is transient in most cases and, providing the fetus is not delivered within 30 to 50 minutes after paracervical block, it has a good chance of being born in vigorous condition.[136,161]
8. Paracervical block should be avoided in prematurity, placental insufficiency or situations where fetal distress has already been manifested.[147] The fetal condition should be properly assessed before PCB and fetal heart tracing is preferably recorded before the block.

In summary, the regional anesthetic technique in order of safety for fetus and newborn are spinal, epidural, caudal, then paracervical, and the drug of choice is bupivacaine.

3. fetal distribution of local anesthetics—Finster[53] has recently studied the distribution of lidocaine in pregnant guinea pigs. Following intravenous injection of lidocaine in the mother (10 mg/kg), fetal levels of the drug in the blood and most parenchymatous organs were found to be consistently lower than maternal levels. The only parenchymatous organ exhibiting higher fetal than maternal lidocaine levels was the liver. This was attributed to the strategic position of the liver in the fetal circulation as well as to the deficiency of the fetal and newborn liver in drug-metabolizing enzymes.[58]

On the whole, compared with general anesthesia, regional analgesia has been associated with excellent Apgar scores[28,75,97,117] and, in the author's opinion, for most cases, it is the best and safest method of control of obstetric pain during labor, delivery and cesarean section.

J. Dissociative Anesthetics—Ketamine will be discussed as an example of this anesthetic group. Ketamine, a phenocyclidine derivative, has recently been used in obstetrics.[25,90,95,103,107] It has the following advantages:

1. Rapid induction.
2. Intense analgesia so that 100 percent oxygen can be used until the fetus is delivered.[103]
3. Strong uterine contractions[83,95] with decreased possibility of postpartum bleeding.
4. Rise of blood pressure. This makes it a suitable induction agent in cases of antepartum hemorrhage and hypotensive conditions of the mother.
5. Easy airway maintenance and less obtundation of the protective pharyngeal and laryngeal reflexes than other induction agents.
6. Minimal respiratory depression with slow injection of low doses required for light anesthesia. This is advantageous because it abolishes the hyperventilation and respiratory alkalosis associated with labor.
7. Bronchodilator effect. Ketamine is recommended for patients with asthmatic disease.[31]

However, ketamine has certain disadvantages for the mother, namely:

1. Hallucinations and unpleasant dreams. These can be reduced, but not eliminated completely by proper use of adjuvant drugs such as droperidol.[140]
2. Rise of blood pressure. Therefore, it is not a suitable anesthetic for mothers with hypertensive disease, e.g., preeclampsia.
3. Although it causes minimal obtundation of the upper airway reflexes, cases of aspiration have been reported following its administration.[121]
4. With excessive speed and/or excessive dosage, maternal respiratory depression and apnea occur.[95] This apnea is accompanied in both mother and fetus by a relatively stiff chest that makes effective controlled respiration difficult.[146]
5. The increase in the uterine tone produced by ketamine may decrease the placental perfusion thus contributing to fetal depression.
6. Excessive salivation, nausea and vomiting in two thirds of obstetric cases.[95]

During labor, ketamine and one of its two metabolites cross the blood-placental barrier.[95] The maternal level is always higher than the fetal level. The maternal/fetal ratio reaches a steady level as early as five minutes with little subsequent variation. The clinical effects of ketamine transmission on the fetus and newborn are still debatable. Some authors consider it to have no harmful effect.[25,90,103] However, others found that it caused lowering of the fetal pH and increased PCO_2 with a variable effect on $Pa0_2$.[95] These changes were reflected by increased fetal depression, as indicated by low Apgar scores at one minute (average four to six).[95,107]

Endotracheal intubation for neonatal resuscitation was required in a number of cases but was difficult because of excessive muscle tone.[171] After the initial depression, all infants returned rapidly to normal as evidenced by the high Apgar score at five minutes (average eight) and ten minutes (average nine). The ketamine fetal depression is proportionate to the dose given to the mother. Recently, with a low intravenous dose of 0.2-0.4 mg/kg and dosage limit of 100 mg, fetal and maternal depression are minimal.[2]

Whether ketamine offers advantages over other available drugs used in obstetrics, and whether its use is safer for the fetus and neonate, await further studies. Until these studies are completed, the author does not recommend ketamine in obstetrics except as an induction agent in emergency hypotensive conditions or in the asthmatic mother.

K. Inhalation Anesthetics—All

inhalation anesthetic gases or vapors pass through the placental membrane rapidly. Their high speed of transfer is related to their rapid rate of diffusion, relatively high fat solubility and usual low molecular weight. Administered in analgesic concentration with the mother awake, oriented and cooperative, no significant depression of the newborn is seen regardless of duration of administration and agent used.[19] However, when administered in anesthetic concentrations, the degree of neonatal depression is proportionate to the depth and duration of maternal anesthesia.

1. nitrous oxide—Earlier studies [29,153] indicated that the fetal blood levels of nitrous oxide were 50-65 percent of the maternal levels. However, recent studies using more refined techniques of measurements show that fetal/maternal ratio averages 80 percent after anesthesia has exceeded three minutes.[101] Uptake of the agent by fetal tissues is also rapid with umbilical artery-vein blood nitrous oxide concentration ratio increasing progressively with duration of anesthesia.[101] This leads to buildup of nitrous oxide in fetal brain with subsequent fetal depression proportionate to induction delivery time. This fetal transmission of nitrous oxide is unrelated to maternal carbon dioxide tension or pH and occurs in both vaginal delivery and cesarean section. Although transmission of nitrous oxide to the fetus is rapid, equilibration across the placenta is not as rapid as saturation of other vessel-rich organs of the mother. Thus, after 10 to 14 minutes of nitrous oxide administration, the fetal/maternal concentration ratio was only 0.8, whereas richly-perfused organs, such as the heart or the brain of the mother, have almost complete saturation.[101] This is due to the unhomogenous condition of the blood in the intervillous space as well as to the absence of continuity of the circulation from mother to fetus.

The conclusion is that the increased incidence of neonatal depression following nitrous oxide anesthesia exceeding 15 minutes may represent fetal narcosis. In addition, diffusion hypoxia plays an important role as a cause of fetal depression. Rapid diffusion of nitrous oxide from pulmonary capillary blood to alveoli commences with the first breath of life and this process reduces oxygen partial pressure in the fetal alveoli resulting in hypoxemia and fetal depression.[30,132] *Therefore, it is the policy in our department that every newborn delivered after nitrous oxide anesthesia to the mother should receive oxygen by face mask for at least a few minutes, irrespective of its Apgar score.*

2. methoxyflurane—Methoxyflurane and its metabolites crosses the blood-placental barrier rapidly with the potential effect of fetal and neonatal depression.[144,165] However, the acid-base status of infants delivered under methoxyflurane anesthesia is normal.[26,32]

There is considerable fetal uptake of methoxyflurane whether the latter is used for analgesia or anesthesia. This is indicated by the higher level of umbilical vein concentration than that of the umbilical artery.[91] Clark and associates[26] found a correlation between methoxyflurane level in umbilical vein and artery and fetal depression. They set critical levels of methoxyflurane in the fetus beyond which fetal depression is liable to occur. The critical level in the umbilical vein is 6 mg/100 ml and in the umbilical artery is 3 mg/100 ml. However, no such correlation was found by other investigators.[92,151] In analgesic concentrations, methoxyflurane does not depress the fetus.[27,92] In anesthetic concentrations it can depress the fetus depending on duration of anesthesia and concentration used, as evidenced by the following studies:

(a) If methoxyflurane was used for obstetric anesthesia for short periods of time (1 to 15 minutes) e.g., for vaginal delivery, the maternal blood level was high (4.25 mg/100 ml). However, the mean umbilical vein and artery levels were low (1.99 mg/100 ml and 0.85 mg/100 ml, respectively) and the neonates were not depressed.[27] The shortness of the time during which the mothers were exposed to the anesthetic apparently prevented high levels from occurring in these infants.

(b) When methoxyflurane was used intermittently as analgesic for labor, then as an anesthetic for the actual delivery, the mean methoxyflurane level in the maternal venous blood was higher (5.45 mg/100 ml). The mean blood levels in umbilical vein and artery were higher (3.68 mg/100 ml and 1.69 mg/100 ml, respectively) and about one sixth of the neonates were depressed.[27]

(c) When 0.1 percent methoxyflurane was used to supplement nitrous oxide and oxygen muscle relaxant anesthesia for cesarean section, there was no fetal depression related to methoxyflurane.[92] The mean maternal artery level at delivery was low (1.72 mg/100 ml) and the mean umbilical vein level was even lower (0.54 mg/100 ml). The low concentration of methoxyflurane used here (0.1 percent), in contrast to the higher concentrations in the other methods mentioned above (average 0.5 percent), explains the lower levels of the drug in both the mother and fetus and better conditions of the neonates.

3. halothane—Halothane has been used in obstetric anesthesia.[12,42,84,106,157] However, halothane can cause maternal hypotension and relaxation of the uterus with the possibility of postpartum hemorrhage. Moreover, it rapidly crosses the blood-placental barrier[145] with the potentiality of neonatal depression. Therefore, many anesthesiologists believe that halothane has little place in obstetric anesthesia. However, recently, Moir[106] used a small concentration of halothane to supplement nitrous oxide and oxygen for general anesthesia for cesarean section. He found that muscle relaxants and nitrous oxide and oxygen (70:30) were accompanied by more depressed newborns than when using muscle relaxants and nitrous oxide and oxygen (50:50) supplemented by 0.5 percent halothane. The administration of 0.5 percent halothane to the mother did not cause neonatal

depression. By allowing an increase in the percentage of oxygen in the nitrous oxide-oxygen mixture, the condition of the newborns was better. This was in agreement with the work of Rorke, et. al.,[137] who found that as the maternal $Pa0_2$ rose towards 300 mm Hg fetal oxygenation and neonatal Apgar scores improved. Halothane, 0.5 percent, did not lead to maternal hypotension or increase in the postpartum hemorrhage. Moreover, the incidence of awareness of the mother during general anesthesia was zero percent with halothane addition compared with 2 percent when only nitrous oxide and oxygen were administered.[106] Although halothane crosses the blood-placenta barrier rapidly, the maternal level is always higher than the fetal level even after prolonged administration. The use of 0.7 percent halothane was accompanied by maternal hypotension and more fetal depression and is not advisable.

4. cyclopropane—Cyclopropane, like all other inhalation anesthetics, has no depressant effect on the fetus in analgesic doses. In anesthetic doses it does depress the fetus. The fetal depression is proportionate to the duration of anesthesia and the concentration of cyclopropane in the anesthetic mixture. Fetal transmission has been studied by many investigators.[4,77,139,152] Cyclopropane can be detected in the umbilical cord blood within 1.5 minutes of its administration to the mother. Subsequently, both the fetal and maternal blood levels rise with increased duration of anesthesia. Fetal blood level usually reaches 80 percent of maternal blood level.

5. diethyl ether—Ether is rapidly transmitted to the fetus. The level in fetal blood is proportionate to duration of anesthesia and ether concentration. Fetal blood concentration can reach 96 percent of maternal blood concentration within 15 minutes.[154]

6. trichloroethylene—Owing to its high lipid solubility, trichloroethylene is very rapidly transmitted to the fetus and fetal blood level can exceed maternal blood level in 16 minutes.[72] This is due to the greater affinity of the drug for fetal than maternal blood.

7. chloroform—Chloroform has low molecular weight and high fat solubility. Therefore, as expected, it passes rapidly to the fetus. In analgesic concentrations, it has no more depressant effect on the newborn than nitrous oxide. In anesthetic concentration, it consistently depresses the neonate.[113]

8. other new anesthetics—Many new anesthetic drugs have been introduced to anesthesia, e.g., ethrane, fluroxene, forane. The most recommended drug of these is fluroxene because of its rapid onset of action, good analgesic properties, increase of cardiac output and peripheral vasodilatation. That is why it is recommended for anesthesia of patients with sickle cell disease.[100] Fluroxene is readily transmitted through the placenta to the fetus.[99] The fetal/maternal concentration ratio is increased with increasing duration and concentration of the anesthetic. However, there has not been significant fetal depression attributed to fluroxene. Fluroxene has a depressant action on uterine contractions which is dose-related.[176] It is also a halogenated compound which does not seem to be free of the problems associated with other halogenated compounds in use, namely, possibility of liver damage.[39] □

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4. Conditional Waiver of the PRA is available (through PMS Office) for those who cannot report sufficient Category I activities but who can give evidence of "keeping up" in other ways.

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Psychiatrists and Physicians—All Levels—Accredited Hospital: Affiliated with approved general hospital for all medical and surgical treatment as required. $22,351 to $29,869 and liberal fringes. Limited housing possible. Pennsylvania license required. Robert L. Gatski, M.D., Director, State Hospital, Danville, Pa. 17821.

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Emergency Room Physician—800 bed, two hospital, teaching medical center located Philadelphia area needs full time E.R. physician. Position includes contract arrangement, paid malpractice and fringe benefits program. Must be Pennsylvania licensed and eligible for BNDD No. Send resume to Department 671, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

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Board Certified or Eligible Psychiatrists—needed at 951 bed modern NP Center; salary up to $36,000 per annum depending on qualifications; excellent fringe benefits; nondiscrimination in employment; full and unrestricted license required; may be from any state; travel and transportation costs may be supported. Contact Chief of Staff, VA Hospital, Leech Farm Road, Pittsburgh, Pa. 15206, or telephone (412) 363-4900, X223 or 244.

Full-Time Emergency Physicians are needed in a 500 bed regional medical center in central Pennsylvania. Emergency department has full-time director, and is actively involved in teaching emergency medicine at all levels. Excellent salary with fringe benefits for 44 hour week. Ideal location to raise a family. Call or write: Thomas C. Royer, Director of Emergency Services, Geisinger Medical Center, Danville, PA 17821, telephone (717) 275-6591.

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Family Physician—N.W. Pa. Assume practice of physician retiring for health. Fully equipped office available. Town is presently without doctor. Hospital 7 miles away. Write Department 663, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

Emergency Room Physician, Experienced—Career oriented physician to organize, staff and supervise a Department of Emergency Services, ultimately consisting of five (5) physicians. Salary dependent upon qualifications. 200 bed general hospital, located in Indiana, Pa., a university community, 1 hour driving distance from Pittsburgh, Pa. Reply to: M. C. Williams, M.D., Chairman, Recruitment Committee, Indiana Hospital, Indiana, PA 15701.

Primary Care/Internal Medicine—University of Pittsburgh. Position available July 1, 1975 in Montefiore Hospital sponsored community health center. Responsibilities include participation in University of Pittsburgh's Health Center primary care training program with appropriate faculty appointment. Write David P. Segel, M.D., Montefiore Hospital, 3459 Fifth Ave., Pittsburgh, PA 15213.

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GP/FP—Community Memorial Hospital based group wants physician to join 4-man group. 42 hour week, paid malpractice, 4 weeks vacation, 3 weeks education. Near Philadelphia, Wilmington, Baltimore, seashore. Call (215) 869-2431, Dr. Kenna or administrator, West Grove, Pa.

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Family Physicians—openings for physicians in areas of medical care in a large, psychiatric hospital which is fully integrated with community agencies, hospitals and base service units, conveniently located near the city for medicare, medicaid and medical assistance. Salaries range to $28,577, with excellent fringe benefits, including opportunities for continuing medical education. Contact Dr. F.C. Wagenseller, Director of Medical Services, Mayview State Hospital, Bridgeville, PA 15017; (412) 343-2700.

Psychiatrists—Psychiatry Service of University affiliated VA Hospital. Salary to $35,782 per annum plus fringe benefits depending on qualifications. Current unrestricted license in any state of U.S. required. Research and teaching opportunities available. Contact Chief of Staff, North Little Rock Division, VA Hospital, Little Rock, AR 72206. Telephone: (501) 372-8361, Ext. 601. An equal opportunity employer.

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Psychiatrists, Physicians with Psychiatric Experience—Mental hospital in metropolitan area. Easy access to New York, Philadelphia, and close to Pocono resort area. Good salary with excellent fringe and retirement benefits. Pennsylvania license required. Contact: Henry Buxbaum, M.D., Superintendent, Clarks Summit State Hospital, Clarks Summit,. PA 18411. Telephone: (717) 586-2011.

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House Staff M.D.—Licensed in Pa., excellent opportunity cover 200 bed hospital days and 1 night per week, supervise and teach physician assistant team, and participate in new growing hospital in attractive Philadelphia community. $30,000 plus benefits, inexpensive on site housing available. Call Dr. Snyder, Coordinator of Medical Affairs, (215) 483-4550.

Board Certified or Board Eligible Psychiatrists needed at 951 bed modern NP Center; salary up to $36,000 per annum depending on qualifications; excellent fringe benefits; nondiscrimination in employment; full and unrestricted license required; may be from any state; travel and transportation costs may be supported. Contact Chief of Staff, VA Hospital, Leech Farm Road, Pittsburgh, PA 15206, or telephone (412) 363-4900, Ext. 223 or 244.

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obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Elmer John Bertin,** Gladwyne; Jefferson Medical College, 1918; age 80; died February 11, 1975. He is survived by a daughter, three sisters, and two brothers.

• **Harry D. Conley,** Cherry Hill, New Jersey; Hahnemann Medical College and Hospital, 1915; age 84; died September 26, 1974. He is survived by his widow.

• **Anthony J. Cummings,** Scranton; University of Buffalo School of Medicine, 1945; age 55; died March 25, 1975. Dr. Cummings was active in the State Society and the Lackawanna County Medical Society. He was former editor of *The Reporter*, the official publication of the Lackawanna County Medical Society, a member of the American Medical Writers Association, and the State Society's House of Delegates. His widow survives him.

• **Merrill D. Cunningham,** Mt. Union; Jefferson Medical College, 1945; age 74; died February 28, 1975. He was a director of the Huntingdon County Unit, American Cancer Society, and a member of the Association of General Practitioners. His wife and a sister survive him.

• **Elsie Curtis,** Bryn Mawr; Woman's Medical College of Pennsylvania, 1929; age 73; died February 14, 1975. She was a general practitioner for over 40 years and taught clinical pathology and gastroenterology at the Woman's Medical College of Pennsylvania. Information regarding survivors is not available.

• **Jules Medina de Cruz,** Philadelphia; Hahnemann Medical College, 1944; age 62; died February 15, 1975. Information regarding survivors is not available.

• **Van Mashburn Ellis,** Meadowbrook; University of Virginia Medical College, 1930; age 73; died January 23, 1975. Information regarding survivors is unavailable.

• **George Washington Gault,** Harrisburg; University of Maryland Medical School, 1910; age 89; died February 15, 1975. Dr. Gault had served as Perry County coroner and was certified in ophthalmology and otolaryngology. His wife, a son, and three sisters survive him.

• **Agnes Hockaday,** Drexel Hill; Woman's Medical College of Pennsylvania, 1911; age 89; died February 24, 1975. Dr. Hockaday was active in the American Cancer Society and had served as its president and campaign chairman. She had practiced medicine for over 62 years. A niece survives her.

• **Edward J. Holland,** Philadelphia; Temple University School of Medicine, 1926; age 74; died March 8, 1975. He was a member of the International College of Surgeons. His daughter survives him.

• **Harry C. Nyce,** Lansdale; Temple University School of Medicine, 1939; age 59; died February 26, 1975. He was chief surgeon at North Penn Hospital. His wife and a son survive him.

• **Ralph B. Roseman,** Philadelphia; University of Maryland School of Medicine, 1936; age 67; died January 10, 1975. Information regarding survivors is not available.

• **Paul R. Sieber,** Pittsburgh; Johns Hopkins University School of Medicine, 1911; age 88; died February 25, 1975. Dr. Sieber had been clinical professor of surgery at the University of Pittsburgh. He was a fellow of the American College of Surgeons, a member of the Pittsburgh Academy of Medicine and American Association of Railway Surgeons, and one of the founders of the Pittsburgh Surgical Society. His wife, two sons, one of whom is Paul R. Sieber, M.D., and a sister survive him.

• **George S. Smith,** Franklin; University of Pittsburgh School of Medicine, 1933; age 67; died March 31, 1975. He was a surgeon on the staff of Franklin Hospital for over 40 years and a fellow of the American College of Surgeons. He is survived by his wife, two sons, and a daughter.

• **Julian A. Sterling,** Hollywood, Florida; University of Pennsylvania School of Medicine, 1936; age 62; died February 23, 1975. He was former assistant professor of surgery at the University of Pennsylvania School of Medicine. He had been chief surgeon at the Philadelphia Psychiatric Center and attending surgeon at Albert Einstein Medical Center. Dr. Sterling developed the first successful use of artificial bile ducts and was the recipient of several honors and awards for his work. He was medical editor of the *Manual of Drugs and Diseases*. He is survived by his wife, a son, and a daughter.

• **Francisco S. Vallaneuva,** Drexel Hill; Manila Central University Medical School, 1951; age 55; died January 17, 1975. Information regarding survivors is not available.

• **Donald A. Westover, Jr.,** State College; University of Pennsylvania School of Medicine, 1951; age 53; died February 8, 1975. He was a fellow of the American College of Surgeons. His widow, parents, three daughters, and a brother survive him.

• **Gomer T. Williams,** Southampton; Jefferson Medical College, 1919; age 82; died September 2, 1974. No information regarding survivors is available.

• **Joseph D. Wolfe,** Pittsburgh; University of Pittsburgh School of Medicine, 1939; age 61; died February 22, 1975. He was a fellow of the American College of Surgeons. He is survived by his wife, a son, two daughters, and his mother.

Stanley M. Stapinski, Glen Lyon; Jefferson Medical College, 1933; age 80; died March 11, 1975. He had been Luzerne County coroner, chairman of the State Society's Committee on Forensic Medicine, a member of the PaMPAC board of directors, and a member of the New York Academy of Sciences. His widow, a daughter, three brothers, one of whom is Cyril Stapinski, M.D., and four sisters survive him.

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Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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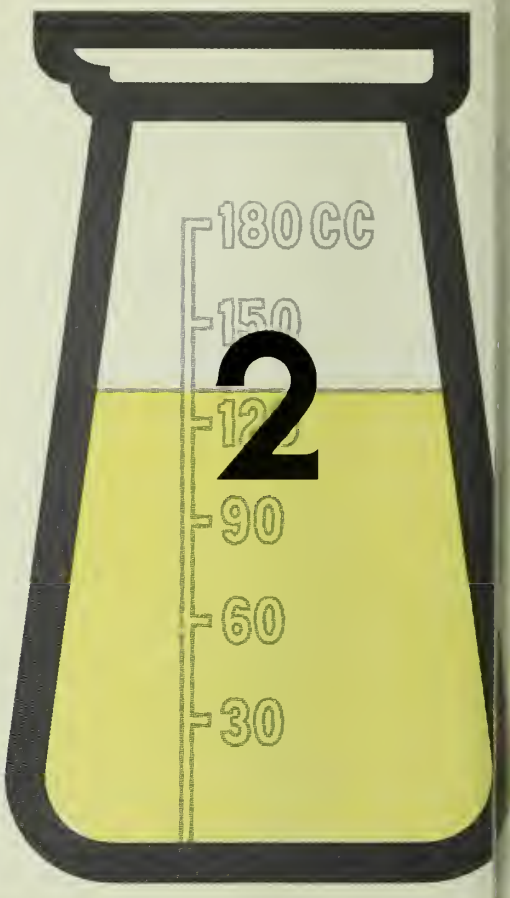

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Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

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Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

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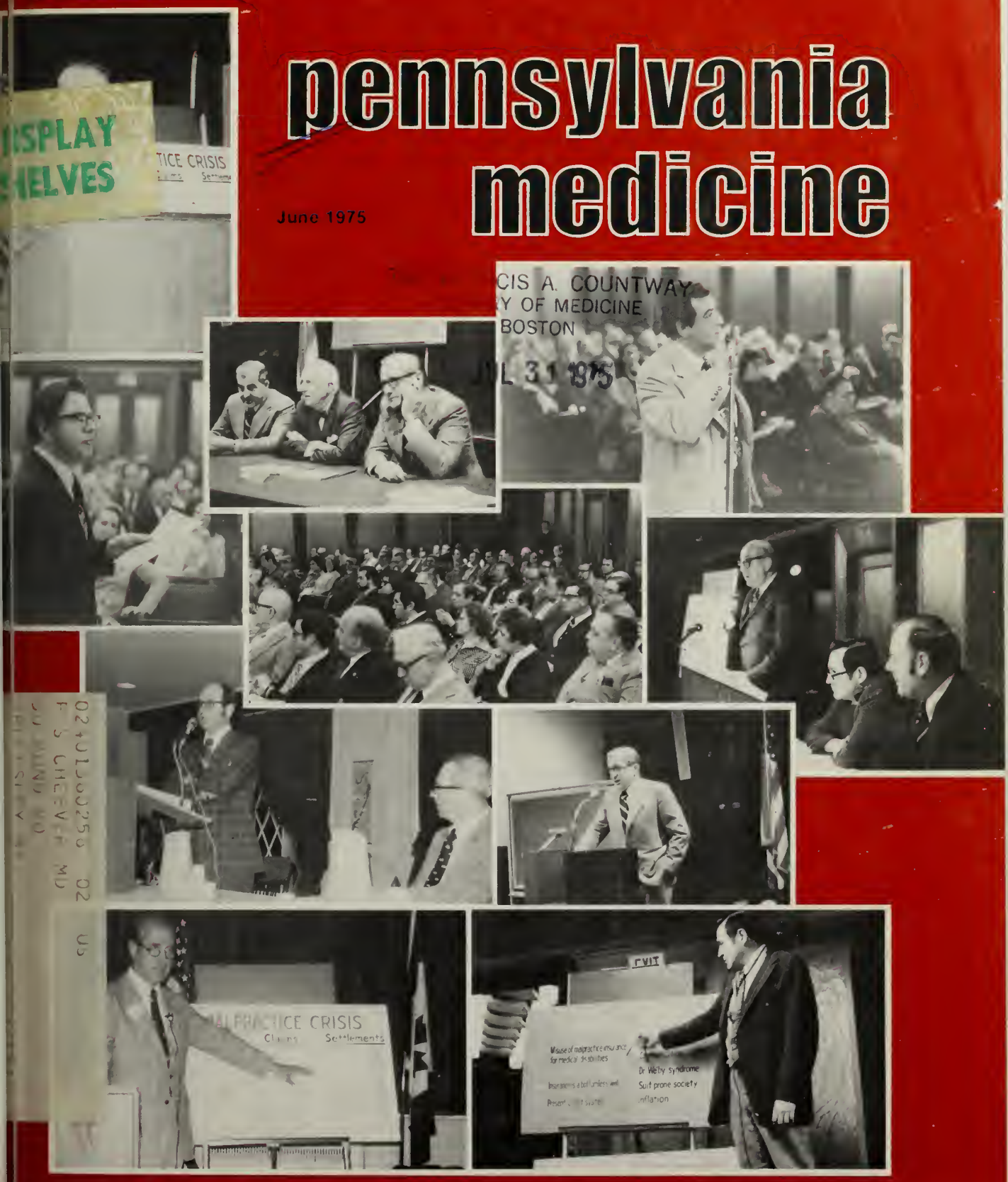
pennsylvania medicine

June 1975



Malpractice crisis action in districts

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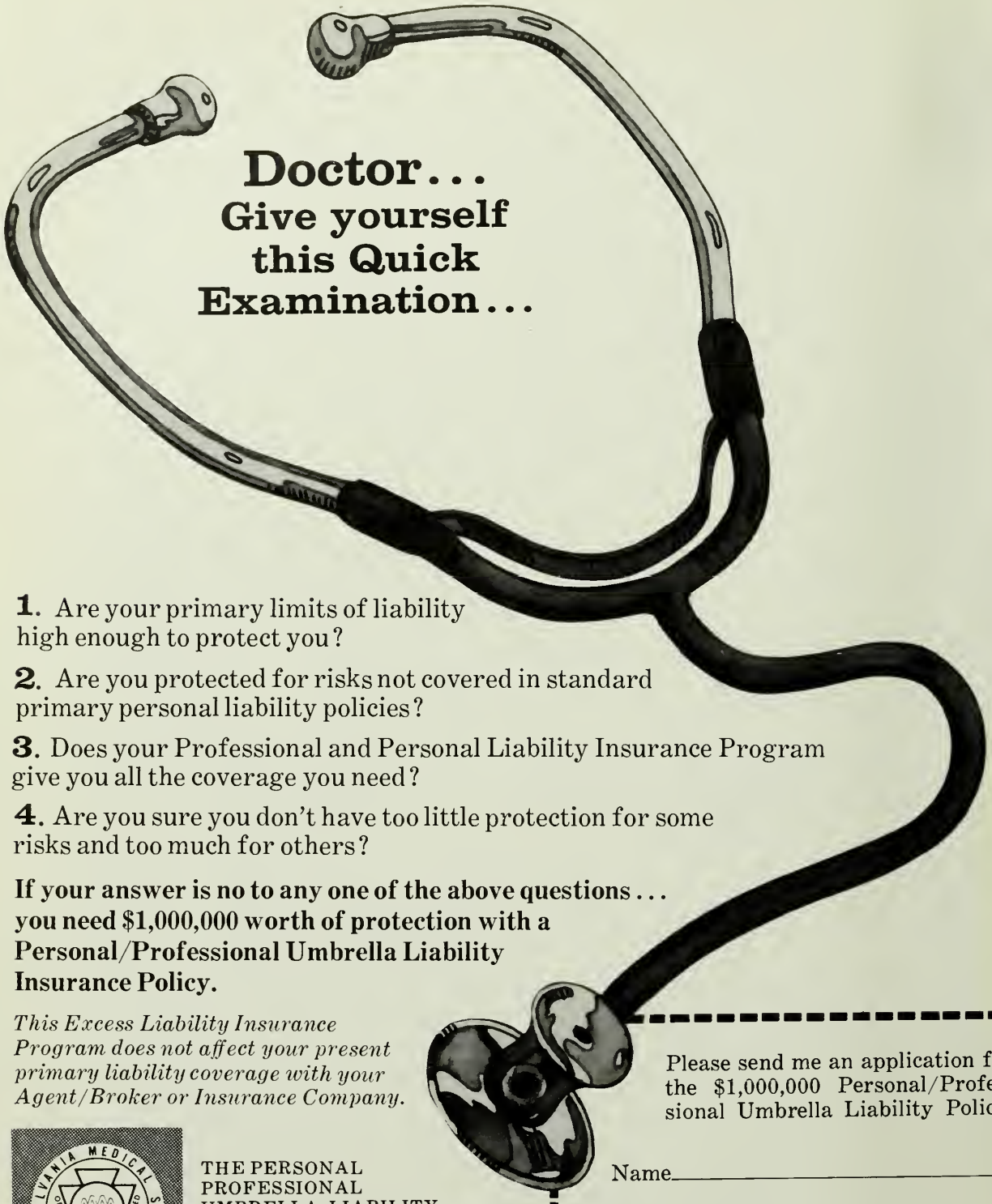

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BOARD CALLS SPECIAL HOUSE SESSION The Board of Trustees has issued a call to a special session of the House of Delegates July 2 and 3 at the Penn Harris Motor Inn, Camp Hill. The Official Call is attached to this Medigram. Malpractice action is the only subject for consideration. John B. Lovette, M.D., speaker of the House, has sent instructions to delegates that only resolutions on this subject will be considered. One reference committee will be appointed to consider resolutions and the report of the Board of Trustees on malpractice action to date. Dr. Lovette's instructions are on the reverse of the Official Call. All Society members may attend and speak at the reference committee hearing. The decision to call delegates into session was affirmed at a special meeting on May 29 of chairmen of the 805 Committees which have been appointed by component county medical societies. The 805 chairmen also received an action plan for implementation before the special session to gain support for the principal features of H.B. 805. See page 7 for the status of the legislation.

HEW'S UTILIZATION REVIEW REGULATIONS ENJOINED U.S. District Court Judge Julius J. Hoffman has temporarily enjoined the Department of Health, Education, and Welfare from enforcing the hospital utilization review regulations for medicare and medicaid patients. First announced to be effective February 1, 1975, then postponed until July 1, 1975, the regulations are now inoperable until a hearing is held on a permanent injunction. No date has been set for that hearing. The AMA brought the action against HEW, and was joined by five individual physicians and ten patients.

FIVE PENNSYLVANIA PSROs NOW CONDITIONAL Five of the Commonwealth's twelve Professional Standards Review Organizations have moved from planning to conditional status. They are Allegheny PSRO, April 16; Southwestern Pennsylvania PSRO, May 6; Philadelphia PSRO, May 6; Montgomery Bucks PSRO, May 6; and Southcentral Pennsylvania PSRO, May 6. For a PSRO status report presented at Officers' Conference see page 43 of this issue.

HEW STUDYING HSA PROPOSALS With all Health Service Area proposals in except California's, the Department of Health, Education, and Welfare's regional offices are reviewing them in preparation for a June meeting in Washington to make final area determinations prior to moving into selection of Health Systems Agencies. See page 9 of this issue for a map of the proposal submitted by Governor Milton J. Shapp.

COOPERATIVE HIRES MANAGER H. Robert Davis, M.D., president of the Pennsylvania Medical Cooperative has announced the appointment of Jack Hogan as manager of the Cooperative. Board of Trustees members who will serve as ex officio members of the Co-op Board of Directors as a result of action at the Board's May 14 meeting are Drs. Kenneth B. Cooper, M.D., of the Seventh Councilor District, and George A. Rowland, M.D., of the Fourth Councilor District.

PENNSYLVANIANS ACTIVE AT AMA SESSION When the AMA's House of Delegates convenes June 15, several Pennsylvania delegates will play key roles. R. William Alexander, M.D., of Reading, will serve on the Reference Committee on Legislation; and William J. Kelly, M.D., of Pittsburgh, vice president of the State Society, will serve on the Reference Committee on Medical Education. William Y. Rial, M.D., of Swarthmore, is vice speaker of the House of Delegates and also serves on the Council on Constitution and Bylaws, along with M. Louise C. Gloeckner, M.D., of Conshohocken. Russell B. Roth, M.D., immediate past president of the AMA, is a member of the Board of Trustees. Paul S. Friedman, M.D., of Philadelphia, is a member of the Council on Legislation. The Pennsylvania Delegation has announced its intention to submit in nomination for the office of president elect the name of William A. Sodeman, M.D., of Toledo, Ohio, a member of the Philadelphia County Medical Society. More about Dr. Sodeman, the 1975 Strittmatter Award recipient, appears on page 12 of this issue.

DR. MASLAND TESTIFIES ON H.B. 853 The House Committee on Health and Welfare held public hearings throughout the state during the Legislature's recess on H.B. 853, the Comprehensive Health Care Act. David S. Masland, M.D., of Carlisle, Society president elect, presented the Society's position in opposition to the bill on May 29 in Harrisburg. The Board of Trustees reaffirmed this position at its May 14 meeting.

WATCH FOR 'A STITCH IN TIME' A special two and one-half hour broadcast on emergency health care in Pennsylvania, "A Stitch in Time," will be broadcast on the seven member stations of the Pennsylvania Public Television Network (PPTN) on Thursday, June 19, at 7:30 p.m. Check your local listings for the exact time in your area.

PHYSICIAN/NURSE-MIDWIFE CONCEPT EXPLORED June 25, 26, and 27 are are the dates of a conference on the physician/nurse-midwife concept at College Misericordia. Eighteen elective continuing education credits are available. Contact Maternal Health Services of Northeastern Pennsylvania for more information. Telephone (717) 824-8797.

PENNSYLVANIA MEDICAL SOCIETY

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OFFICIAL CALL

June 2, 1975

TO: Presidents, Secretaries, Delegates and Executive Secretaries of Component County Medical Societies

Dear Doctor:

The Board of Trustees and Councilors of the Pennsylvania Medical Society determined on May 22 to call a special session of the House of Delegates.

This Official Call is issued pursuant to Article VII, Section 2 of the Constitution.

The special session will convene at the Penn Harris Motor Inn, Camp Hill, Pennsylvania, Wednesday, July 2, 1975 at 1:00 p.m. The second and concluding session will begin at 9:30 a.m., Thursday, July 3, 1975.

The purpose of the session is to review the progress of the professional liability insurance crisis and the Society's response to it; the current status and future prospects of remedial legislation; and to formulate policy and actions for the Society's further response to the crisis.

Noting that the terms of reference committees end May 31 (Chapter III, Section 9) and that component societies must have their new delegations elected by June 1 (Chapter XVI, Section 10), I hereby issue this call to the new delegates, who would normally be certified and attend this year's annual meeting in October, 1975.

Agenda materials will be issued prior to the meeting. The Speaker of the House, John B. Lovette, M.D., will appoint the necessary reference committees shortly.

Sincerely,

G. Winfield Yarnall, M.D.
Secretary

TO: Delegates DATE: June 2, 1975

FROM: John B. Lovette, M.D. SUBJECT: Resolutions for Special Ses

---

As mandated in Article VII, Section 3 of the Constitution, Resolutions submitt for consideration by a special session of the House must pertain to the matter expressly stated in the call for the Special Session.

Resolutions may also be submitted at any time prior to the Special Meeting of the House. Those received prior to June 24 will be duplicated and included in the mailed agenda materials. Those which arrive after the mailing but prior to the opening of the House of Delegates will be distributed at registration and shall require a two-thirds favorable vote of the members of the House of Delegates prese and voting at the first meeting of the House to become the business of the House.

All resolutions must be introduced by a member of the House acting in his own behalf or for the component county medical society or specialty society he represe

Resolutions emanating from and approved by the Board of Trustees may be submitted directly to the House of Delegates at any time prior to or during the session, at the discretion of the Speaker.

All resolutions are to be submitted to the Secretary of the Society in two copies and should indicate that they are directed to the Special Session.

The Speaker of the House during the session of the House shall have the right to declare any resolution out of order in accordance with the principles of Sturgis Standard Code of Parliamentary Procedure.

All resolutions submitted to the Special Session of the House of Delegates must concern the business before the House as stated in the Official Call.

pennsylvania medicine

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JUNE 1975 VOLUME 78, NUMBER 6

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PENNSYLVANIA MEDICINE, established in 1897, is published monthly as the official publication of the Pennsylvania Medical Society. All original papers and correspondence should be directed to the Managing Editor. Subscription requests and changes of address should be sent to PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043. A subscription is $5.00 per year. Single issues are 50 cents. Second class postage is paid at Lemoyne, Pennsylvania 17043.

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in fr and/or severity of grand mal seizu require increased dosage of stand convulsant medication; abrupt wit may be associated with temporary crease in frequency and/or severi seizures. Advise against simultane gestion of alcohol and other CNS c sants. Withdrawal symptoms (sim those with barbiturates and alcoh occurred following abrupt discont (convulsions, tremor, abdominal a cle cramps, vomiting and sweatin addiction-prone individuals under

respond to one

According to her major
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:ription she gives of her
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sound like depression.
s is because her problem,
ough primarily one of ex-
ive anxiety, is often accom-
ied by depressive symptom-
ogy. Valium (diazepam)
provide relief for both—as
:xcessive anxiety is re-
:d, the depressive symp-
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s in using Valium for the
agement of psychoneu-
: anxiety with secondary
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um is pronounced and
d. This means that im-
ement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

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o habituation and dependence. In
ancy, lactation or women of child-
ng age, weigh potential benefit
st possible hazard.

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lly pharmacology of agents em-
d; drugs such as phenothiazines,
tics, barbiturates, MAO inhibitors
ther antidepressants may potentiate
ion. Usual precautions indicated in
nts severely depressed, or with latent
ssion, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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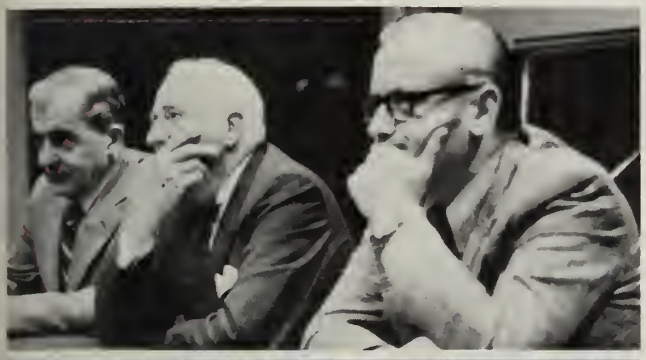
president's page

Malpractice crisis demands integrated action



THROUGHOUT the state physicians have coordinated their efforts to solve the malpractice crisis. Photographs on the cover depict action in the districts. The photographs directly above show a meeting of the First District. In the top photograph are Donald R. Cooper, M.D., trustee and councilor; Dr. Crane; and John F. Rineman, executive vice president. To the right above, John J. Danyo, M.D., chairman of the Commission on Professional Liability Insurance, addresses an audience of leaders of related professions. To the right below, the malpractice situation is discussed at the meeting of the Interspecialty Committee. Shown are Joseph M. Stowell, M.D., trustee of the Sixth District; Dr. Crane; and Robert M. Pressman, M.D., chairman of the committee.

While we have succeeded through settlement and court order in requiring the Argonaut Insurance Co. to honor its contract and continue malpractice coverage for Pennsylvania physicians, the victory is a bitter one. It has been bought at a marked increase in premiums requiring insured doctors to pay from $1,500 to $25,000 or more for the privilege of practicing medicine in Pennsylvania. This is an excise leveled against no other profession. It will add precipitously to the cost of medical care and ultimately will come from the pockets of those least able to afford it—the sick and injured.

At our instigation Pennsylvania Blue Shield has taken action to make interest free loans available to participating physicians to help make payments on their malpractice insurance. Means for securing prompt increases in fee schedules and prevailing fees also are being pursued by Blue Shield.

With the settlement of the Argonaut suit we have bought time—time to strive for legislation which will effect changes in the system for evaluating instances of alleged malpractice with an equitable solution for all—the rightly aggrieved, providers of care, and society as a whole. The present state of the legislative effort is as follows:

1. Legislative proposals, including our H.B. 805 (in-

troduced by Representative Shane), H.B. 1129 (introduced by Representative Salvatore), and the Insurance Department bill, announced as an Administration package on May 14 by Governor Milton J. Shapp (not yet identified officially), are being referred to the House Judiciary Committee, chaired by Representative Norman S. Berson.

2. The Insurance Department bill centers about the provision of coverage through a state-sponsored but privately supported joint underwriting association and as written perpetuates all of the flaws and travesties of the present system, even establishing a 33⅓ percent contingency fee as legal. The Society's legislation is concerned with changing the system. Without that change any form of continuing coverage simply continues the untenable costs of the present system.

3. At a special meeting on May 7, the Governor assigned his legislative assistant, William B. McLaughlin, III, to work with the Society's legal counsel to dovetail the best aspects of both bills so that a proposal worthy of wide support can be put before the State Legislature.

4. On May 9, Chairman Berson reviewed the legislative problems with me. He emphasized that both proposals will require modification to gain acceptance from a lawyer dominated Legislature. He expects that a bill sponsored by his committee will be ready for presentation to the House shortly after it reconvenes in June.

5. The public information campaign is being stepped up at the local level. Newspaper advertising is scheduled. Hundreds of you are cooperating in the distribution of an information pamphlet to your patients and friends. Over 300,000 of these already have been distributed. Many of you are accepting speaking engagements to present the problem to civic groups in your community. All of our activities at this time must be coordinated and must be aimed at producing a positive result—malpractice reform legislation.

At this moment it appears that our message has reached both the Administration and the Legislature. I believe that there is a hope significant legislation may be enacted. It is appropriate for us to see what that legislation is and base our future actions thereon. Therefore after the Legislature reconvenes and not later than June 15, appropriate and integrated courses of action will be recommended to you through the 805 committees. Until that time I urge that group actions be held in abeyance to give the lawmakers a fair chance to show their good faith.

A. Reynolds Crane, M.D.
President

Under P.L. 93-641

Governor submits Health Service Area Proposal

The map below shows the Health Service Area (HSA) proposal as submitted to the Department of Health, Education, and Welfare by Pennsylvania's Governor Milton J. Shapp early in May. Final decision on HSAs will be announced by HEW Secretary Caspar Weinberger, and is expected to be made in August. Following that a network of Health Systems Agencies responsible for local health planning will be established.

At Officers' Conference

Environmental award winners receive Society acclaim

The Society presented the annual Environmental Improvement Recognition Awards at the 1975 Officers' Conference, April 23-24.

The individual award was presented to W. G. "Turk" Jones, of Philipsburg, for his work in reclamation of strip mining areas. He has been responsible for the planting of 36 million trees during the last 25 years and has used over $50,000 from his personal funds, in addition to contributions made by the bituminous coal companies, to carry on the reclamation.

P. H. Glatfelter Company, Spring Grove, received the award as a company which has worked to combat pollution. The paper manufacturer invested $3 million in waste treatment facilities which resulted in great improvement of Codorus Creek, once a badly polluted stream.

The third recipient was the French and Pickering Creeks Conservation Trust, Inc., a Pottstown voluntary group which aims at preserving open space and historic sites in its area.

State's approved dialysis centers listed

Since 1971 the Pennsylvania Department of Health has maintained a program by which any resident of the state, regardless of financial status, can obtain treatment for chronic kidney disease. George Jones, M.D., director of the state's Chronic Renal Disease Services, stated that a monthly average of 36 new patients were admitted to the program in 1974, with a total of 1,373 patients using the artificial kidney. The monthly average for new admissions for the first three months of 1975 was 53.

The cost of hemodialysis has decreased considerably from the 1960s, but can still range from $15,000 to $25,000 for the first year of treatment. Because of the state program with availability of financial aid, the awareness of health professions of the program, and most of all, the availability of more facilities, more patients have been able to obtain treatment for chronic kidney disease.

The following is a list of state approved hemodialysis centers and affiliate units in the state and near its borders:

ALLEGHENY COUNTY

Allegheny General Hospital
320 East North Avenue
Pittsburgh, PA 15212

Bio-Medical Applications of Pittsburgh, Inc.
at St. Francis General Hospital
45th Street (Off Penn Avenue)
Pittsburgh, PA 15201

Presbyterian University Hospital
230 Lothrop Street
Pittsburgh, PA. 15213

BLAIR COUNTY

Altoona Hospital
Howard Avenue & 7th Street
Altoona, PA 16603

CAMBRIA COUNTY

Mercy Hospital of Johnstown
1020 Franklin Street
Johnstown, PA 15905
AFFILIATE OF: Presbyterian University Hospital

CENTRE COUNTY

Centre Community Hospital
State College
Bellefonte, PA 16801

DAUPHIN COUNTY

Harrisburg Hospital
South Front Street
Harrisburg, PA 17101

Harrisburg Polyclinic Hospital
Third and Polyclinic Avenue
Harrisburg, PA 17105

The Milton S. Hershey Medical Center
Hershey PA 17033

DELAWARE COUNTY

Crozer-Chester Medical Center
15th Street & Upland Avenue
Chester, PA 19013

Delaware County Memorial Hosp.
Lansdowne & Keystone Avenue
Drexel Hill, PA 19026

Shadeland Medical Center
Dialysis Clinic
211 Shadeland Avenue
Lansdowne, PA 19050
AFFILIATE OF: Delaware County Memorial Hospital

ERIE COUNTY

Hamot Medical Center
P.O. Box 339
Four East Second Street
Erie, PA 16512

LACKAWANNA COUNTY

Moses Taylor Hospital
700 Quincy Avenue
Scranton, PA 18510

LANCASTER COUNTY

Lancaster General Hospital
555 North Duke Street
Lancaster, PA 17604

LEHIGH COUNTY

Allentown Hospital Association
17th and Chew Streets
Allentown, PA 18102

Continued on page 32

Bicentennial birthday present

Society asks members' support in Bicentennial project

The Society has chosen as its Bicentennial project the restoration of the Benjamin Rush House. Rush, the only signer of the Declaration of Independence holding a medical degree, contributed much to the growth and development of medical science in the United States.

Dr. A. Reynolds Crane, Society President, has sent a letter requesting contributions from all members to help support reconstruction costs. The Society's goal is $150,000.

The 275 year old house, built by Benjamin's grandfather, had stood near the corner of Red Lion and Academy Roads in northeast Philadelphia. It was the only existing birthplace of a signer of the Declaration. In 1969 it was demolished by mistake when an apartment complex was built on the old Rush homestead. A group of concerned citizens, which initiated action by forming the Benjamin Rush House Committee, had the stones and woodwork transferred to the grounds of the Philadelphia State Hospital where they are now in safekeeping. Robert E. Jones, M.D., associate medical director of Pennsylvania Hospital, is chairman of the committee.

Before the house was razed, vandals had stolen the bronze placque which had been placed on the house in 1935 by descendents of the signers of the Declaration. Kenneth Satchell, Penndel, a retired schoolteacher, heard that the placque had disappeared and that a group of children in a nearby school had it in their possession. He offered a reward for its safe return with no questions asked. The children surrendered it and Mr. Satchell gave it to the Philadelphia State Hospital which has turned it over to the Benjamin Rush House Committee for safekeeping.

The committee has already received permission to re-erect the Rush house on the grounds of the Philadelphia State Hospital. Two proposals for the establishment of Benjamin Rush State Park on the hospital grounds have been introduced into the legislature.

Those who wish to have a part in the Society's Bicentennial restoration project may send contributions to Society Headquarters, 20 Erford Road, Lemoyne, PA 17043.

Internists elect officers

The Pennsylvania Society of Internal Medicine held its 13th Annual meeting April 4-6 in Philadelphia. Among the activities was the election of officers for 1975-76.

The officers are: Raymond C. Grandon, M.D., Harrisburg, president; George Hinkens, M.D., Pittsburgh, president elect; Peter Hillyer, M.D., Paoli, secretary; and James Regan, M.D., Bethlehem, treasurer.

State surgeons meet; present award

The 21st Annual Joint Meeting of the Southwestern Pennsylvania Chapter of the American College of Surgeons, held on April 2, was chaired by Charles E. Copeland, M.D., F.A.C.S., of Pittsburgh. During the meeting the annual award for extraordinary performance as a physician in the service of mankind was given to Claude E. Welch, M.D., F.A.C.S., of Boston, in recognition of his outstanding contributions to the science and teaching of surgery. At the evening banquet Dr. Welch delivered an address on "Medicine in the People's Republic of China."

THE FIFTH COUNCILOR DISTRICT held a joint meeting of members, spouses, and members of the Legislature in May to discuss the malpractice crisis in Pennsylvania. In the top photograph, Raymond C. Grandon, M.D., trustee and councilor, addresses the audience of over 150, including 18 legislators.

Dr. Sodeman named Strittmatter Award recipient

William A. Sodeman, M.D., was the recipient of the Philadelphia County Medical Society's Annual Strittmatter Award for 1974 presented in May. The society's highest honor, the award was established in 1923 by Isadore Paul Strittmatter, M.D.

Dr. Sodeman is currently clinical professor of medicine at the Medical College of Ohio at Toledo. He is former dean and vice president of medical affairs, Magee Professor of Medicine, and head of the department of internal medicine at Jefferson Medical College, Philadelphia, and holds the title of dean emeritus and professor of medicine emeritus of that institution. He has continued membership in the Philadelphia County and Pennsylvania Medical Societies.

Dr. Sodeman has been active in organized medicine. He is past president of the American College of Physicians, American College of Cardiology, American Society of Tropical Medicine, and the Society of Sigma Xi. He has served the American Medical Association in various ways including delegate to the section on cardiovascular disease and chairman of the Council on Medical Education. He also helped to establish the Council on Health Manpower. In addition, the Pennsylvania Delegation to the AMA in January wrote a letter of intention to nominate Dr. Sodeman as a candidate for the office of president elect.

William A. Sodeman, M.D., Strittmatter award winner, attended the Society's successful April Officers' Conference. He is shown on page 15 of this issue in the conference photographic section.

Dr. Sodeman received his undergraduate education and medical degree from the University of Michigan, Ann Arbor. He is board certified in internal medicine, cardiology, and preventive medicine and has served as consultant to the U.S. Public Health Service and the National Institutes of Health. His publications include 195 articles and the monograph, "Pathologic Physiology," which has been translated into five other languages.

Blood bankers hold science session; elect officers

The Pennsylvania Association of Blood Banks held its 18th annual spring meeting April 25 and 26 at the Host Inn, Harrisburg.

The program, chaired by James F. Crispen, M.D., Polyclinic Hospital, Harrisburg, included 25 speakers on various aspects of blood banking, including freeze preservation of human platelets, heptatitis B virus tests, and automation in blood banks.

Officers elected during the meeting were: Eugene A. Bentley, Jr., M.D., West Chester, president; Ernest L. Abernathy, M.D., Washington, first vice president; Miriam B. Dahlke, M.D., Philadelphia, second vice president; Leonard M. Tanner, M.D., Lebanon, secretary treasurer.

PABB officers for 1975-76 are, left to right, Eugene A. Bentley, Jr., M.D., president; Leonard M. Tanner, M.D., secretary treasurer; Ernest L. Abernathy, M.D., first vice president; Miriam B. Dahlke, M.D., second vice president.

Cooperative awards prizes at Officers' Conference

The Pennsylvania Medical Cooperative held its prize drawing for charter members during the 1975 Officers' Conference. The first prize, a trip for two to the British Isles and Holland, compliments of the Lehigh County Medical Society, went to Jorge A. Querimit, M.D., Williamsport. Dr. Querimit is on the active surgical staffs of Williamsport Hospital and Divine Providence Hospital. He is a member of the American College of Surgeons and president of the Lycoming County Unit of the American Cancer Society.

DR. QUERIMIT

Marlin E. Wenger, M.D., Lancaster, won the second prize, which is $500 worth of medical supplies. Winners of the third prize, $250 worth of medical supplies, were Arthur E. Falk, M.D., Lansdale, and Liveo B. Baldia, M.D., Berwick. Donald M. Qualls, M.D., Philadelphia, R. Michael Yeller, M.D., Reading, and W. Howard Henderson, M.D., Chester, won the fourth prize, $100 worth of medical supplies.

The fifth prize, which is $50 worth of medical supplies, went to: Samuel K. Schultz, M.D., Johnstown; James J. Reilly, M.D., Pittsburgh; H. W., Horan, M.D., Wilkes-Barre; F. D. Zimmerman, Jr., M.D., Schaefferstown; Nelson Page Aspen, M.D., Paoli; William B. Thorsen, Jr., M.D., York; Sherwood L. Samet, M.D., East Stroudsburg; Donald P. Zangwill, M.D., Pittsburgh; Frank S. Bryan, M.D., Carlisle; Mario E. Fornasier, M.D., Philadelphia; and Charles H. Greenbaum, M.D., Philadelphia.

Clinic elects officers

The Wainwright Tumor Clinic Association of Pennsylvania held its 45th annual meeting at Thomas Jefferson University in Philadelphia on May 14.

Officers elected at the meeting were: George R. Greenwood, M.D., Bethlehem, president; Kenneth K. Meyer, M.D., Sayre, president elect; Alan W. Shriver, M.D., Greensburg, vice president; John F. Kennard, M.D., Clearfield, treasurer; and James S. Furnary, M.D., Johnstown, secretary.

Elected as directors for a three year term were: M. Peter Scibetta, M.D., Erie; John McA. Ulrich, D.O., Harrisburg; and Harvey Slater, M.D., Pittsburgh.

Chiropractors restrained in settlement

Agreements have been negotiated among the Bureau of Consumer Protection and three central Pennsylvania chiropractors, settling a two year old lawsuit charging the chiropractors with false advertising and disparaging the services of medical doctors. The chiropractors have promised not to advertise deceptively or disparage the services of nonchiropractic healing professionals, without admitting to any wrongdoing on their part.

J. M. Sigafoose, Thomasville, has agreed not to advertise that all patients who follow the chiropractic requirements will be cured, that all health problems can be cured by chiropractic methods, and that medical doctors only give temporary relief. John N. Pikulin, New Cumberland, has promised not to represent that physical illness can only be cured by chiropractic methods and that "pain is a warning that you need a spinal examination." Brian D. Ehrhart, York, has agreed not to claim that "only chiropractic corrects the cause of poor health."

The agreements in effect make permanent by consent the preliminary injunctions issued by Commonwealth Court two years ago. In addition, they permit the chiropractors to compare medicine and chiropractic practices and to use medical journals and other authoritative reporting agencies to advise against the danger of drug overuse and the adverse effects of immunization. They may also offer free x-rays and quote office fee schedules in their advertisements.

Blue Shield record set

Wilbur E. Flannery, chairman of the board of directors for Pennsylvania Blue Shield, has reported that in 1974 a record high of $385 million in benefits was paid for the eight million claims made. The record claims volume was 19 percent above 1973 totals; so far in 1975, claim volume is running 20 percent higher.

About 4.8 million claims were for Blue Shield subscribers. The remaining 3.2 million were for beneficiaries of government programs which Blue Shield administers.

Officers' Conference story seen by camera

H. Robert Davis, M.D., Co-op president and Ellen Haffly conduct drawing

AMA Delegation luncheon

Picking the winner

AMA Delegation luncheon

Dr. Alexander

Dr. and Mrs. McCoy and Dr. Jurka of the AMA Board

Audience shows concern

AMA Delegation luncheon

Officers' Conference dinner—break from business routine

Drs. Grandon, Roth, Sodeman, and Donaldson

Dr. Sanford

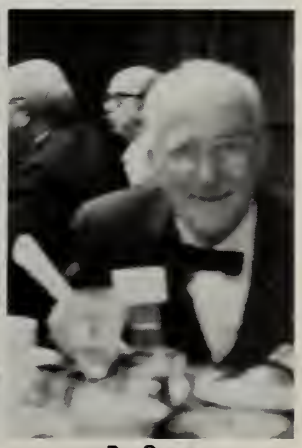
AMA Delegation luncheon

Dr. and Mrs. Slease

Dinner guests

Dr. Rowland

Mrs. Crane



Dr. Crane

Interspecialty Committee meeting during Officers' Conference

Mr. Perry

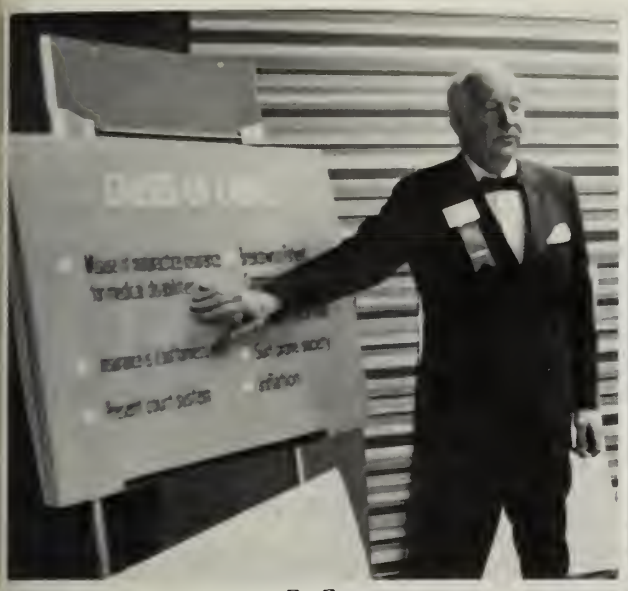
Dr. Schwartz

Dr. Steigerwalt

Dr. McCoy

Interspecialty Committee and Dr. Pressman, chairman, with Mr. McCoy, staff assistant

Speakers' training seminar participants



Dr. Crane

Attentive audience

Dr. Ryan waits to speak

Senator W. Louis Coppersmith

Congressman H. John Heinz

Interspecialty Committee meeting

Allegheny County delegates

Delegates hear about malpractice, MSAs, and PSRO

Elliott R. Knauer of CHP

Tape Presentations Medical Arts '74

An Overview of Acupuncture

Check Programs Desired

- ☐ **A105:** Acupuncture: A Therapeutic Modality—Nathan Sussman, M. D., Harrisburg, Pennsylvania. 25 min.
- ☐ **A106:** Acupuncture and Its Role in Anesthesia—James C. Erickson, III, M. D., Professor of Anesthesiology, Jefferson Medical College. 30 min.
- ☐ **A107:** Acupuncture in the Management of Intractable Pain—Mary E. Moore, Ph. D., M. D., Assistant Professor of Medicine, Temple University Health Sciences Center. 20 min.
- ☐ **A108:** Mechanism and Management of Chronic Pain—Jewell L. Osterholm, M. D., Professor of Surgery (Neurosurgery) and Director, Division of Neurosurgery, Hahnemann Medical College and Hospital. 35 min.

The Physician, The Patient and Long-Term Care

- ☐ **A110:** Our Role in the Care of the Aging—Nathan Sussman, M. D., Medical Director, Dauphin County Home and Hospital, discusses the role of medical and allied professions in the care of the aging. 11 min.
- ☐ **A111:** Applied Geriatrics—Joseph T. Freeman, M. D., Philadelphia, Pennsylvania, discusses new circumstances in older age which reassign obligations but do not lessen responsibilities, the need to make judgments in terms of the older person who is living and dying in accordance with new social imperatives, and overtones to life in old age that cannot be judged by rules of survival at all costs. 25 min.
- ☐ **A112:** Commonly Encountered Medical Problems of the Elderly—Thomas Hart, M. D., Consultant and Member of Faculty, Harrisburg Hospital Family Practice Residency Program. 18 min.
- ☐ **A113:** Demonstrating Quality Control—Leslie Fox, Joint Commission on Accreditation of Hospitals, discusses the development of a quality control program in long-term care facilities. 98 min. (Provide Two Cassettes)

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Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

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But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritating symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

Cold or Allergy?

Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.

CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.

ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia, drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

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Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

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when pain goes on... and on... and on–

For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides ¼ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

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Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

(III) Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

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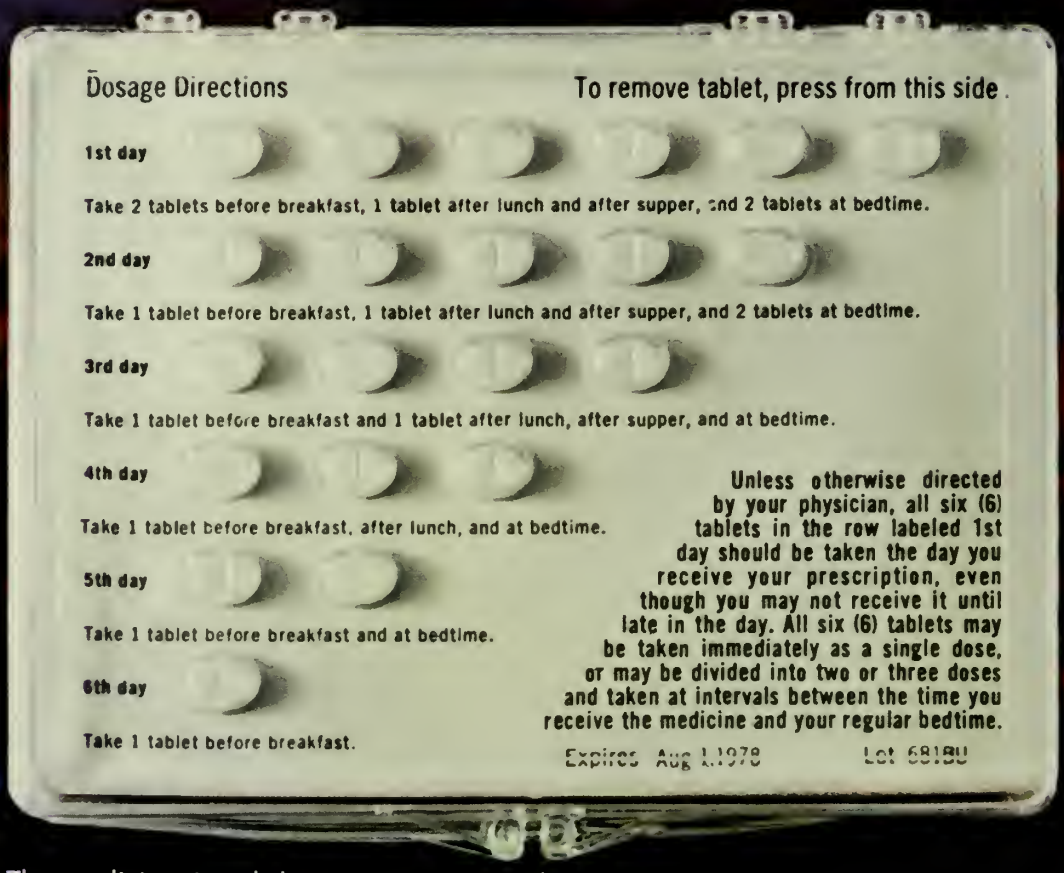
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To remove tablet, press from this side.
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Take 2 tablets before breakfast, 1 tablet after lunch and after supper, and 2 tablets at bedtime.
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Take 1 tablet before breakfast, 1 tablet after lunch and after supper, and 2 tablets at bedtime.
3rd day
Take 1 tablet before breakfast and 1 tablet after lunch, after supper, and at bedtime.
4th day
Take 1 tablet before breakfast, after lunch, and at bedtime.
5th day
Take 1 tablet before breakfast and at bedtime.
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Unless otherwise directed by your physician, all six (6) tablets in the row labeled 1st day should be taken the day you receive your prescription, even though you may not receive it until late in the day. All six (6) tablets may be taken immediately as a single dose, or may be divided into two or three doses and taken at intervals between the time you receive the medicine and your regular bedtime.
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The explicit printed dosage instructions that accompany each Dosepak make it easy for the patient to understand and follow the dosage regimen.

Poison ivy and other severe allergic states intractable to adequate trials of conventional treatment will often respond to a short, intensive, adjunctive course of Medrol. Medrol Dosepak is designed to provide a tapered, six-day course of methylprednisolone tablets.

On occasion, a six-day course of Medrol therapy may not be sufficient and therapy may need to be extended. If there is continued contact with the sensitizing agent, corticosteroids will not completely suppress the inflammatory response. A further caution: If lesions become infected during Medrol therapy, it should be remembered that steroids may decrease resistance to infection and hinder the body's ability to localize an infection.

MEDROL COMPRESSED TABLETS—2, 4 & 16 MG
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DESCRIPTION AND ACTIONS: Medrol (methylprednisolone) is a synthetic glucocorticoid with potent anti-inflammatory effects. It is readily absorbed from the GI tract. Glucocorticoids cause profound and varied metabolic effects and modify the body's immune responses to diverse stimuli.

INDICATIONS: 1. **Endocrine Disorders:** Primary or secondary adrenocortical insufficiency (hydrocortisone or cortisone is the first choice; synthetic analogs may be used in conjunction with mineralocorticoids where applicable; in infancy, mineralocorticoid supplementation is of particular importance). Congenital adrenal hyperplasia; nonsuppurative thyroiditis; hypercalcemia associated with cancer. 2. **Rheumatic Disorders:** As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in: psoriatic arthritis; rheumatoid arthritis (selected cases may require low-dose maintenance therapy); ankylosing spondylitis; acute and subacute bursitis; acute nonspecific tenosynovitis; acute gouty arthritis. 3. **Collagen Diseases:** During an exacerbation or as maintenance therapy in selected cases of—Systemic lupus erythematosus; acute rheumatic carditis. 4. **Dermatologic Diseases:** Pemphigus; bullous dermatitis herpetiformis; severe erythema multiforme (Stevens-Johnson syndrome); exfoliative dermatitis; mycosis fungoides; severe psoriasis. 5. **Allergic States:** Control of severe or incapacitating allergic conditions intractable to adequate trials of conventional treatment: Seasonal or perennial allergic rhinitis; bronchial asthma; contact dermatitis; atopic dermatitis; serum sickness. 6. **Ophthalmic Diseases:** Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as—allergic corneal marginal ulcers; herpes zoster ophthalmicus; anterior segment inflammation; diffuse posterior uveitis and choroiditis; sympathetic ophthalmia; allergic conjunctivitis; keratitis; chorioretinitis; optic neuritis; iritis and iridocyclitis. 7. **Respiratory Diseases:** Symptomatic sarcoidosis; Loeffler's syndrome not manageable by other means; berylliosis; fulminating or disseminated pulmonary tuberculosis when concurrently accompanied by appropriate antituberculous chemotherapy. 8. **Hematologic Disorders:** Idiopathic and secondary thrombocytopenia in adults; acquired (autoimmune) hemolytic anemia; erythroblastopenia (RBC anemia); congenital (erythroid) hyperplastic anemia. 9. **Neoplastic Diseases:** For palliative management of: leukemias and lymphomas in adults; acute leukemia of childhood. 10. **Edematous States:** To induce a diuresis or remission of proteinuria in the nephrotic syndrome, without uremia, of the idiopathic type or that due to lupus erythematosus. 11 **Miscellaneous:** Tuberculous meningitis with subarachnoid block or impending block when concurrently accompanied by appropriate antituberculous chemotherapy. Systemic dermatomyositis (polymyositis).

CONTRAINDICATIONS: Systemic fungal infections.

WARNINGS: In patients on corticosteroid therapy subjected to unusual stress, increased dosage of rapidly acting corticosteroids before, during, and after the stressful situation is indicated.

Corticosteroids may mask some signs of infection and new infections may appear during their use. There may also be decreased resistance and inability to localize infection. Prolonged use may enhance the establishment of secondary ocular infections due to fungi or viruses.

Since adequate human reproductive studies have not been done, the use in pregnancy, nursing mothers or women of childbearing potential requires that the possible benefits be weighed against the potential hazards to the mother and the embryo or fetus. Infants should be observed for signs of hypoadrenalism.

Average and large doses of hydrocortisone or cortisone can cause elevation of blood pressure, salt and water retention, and increased excretion of potassium. These effects are less likely to occur with the synthetic derivatives except when used in large doses. Dietary salt restriction and potassium supplementation may be necessary. All corticosteroids increase calcium excretion.

While on corticosteroid therapy, patients should not be vaccinated against smallpox. Other immunization procedures should not be undertaken in patients who are on corticosteroids, especially on high dose, because of possible hazards of neurological complications and a lack of antibody response.

The use of corticosteroids in active tuberculosis should be restricted to those cases of fulminating or disseminated tuberculosis in which the corticosteroid is used for the management of the disease in conjunction with an appropriate antituberculous regimen.

If corticosteroids are indicated in patients with latent tuberculosis or tuberculin reactivity, close observation is necessary as reactivation of the disease may occur. During prolonged corticosteroid therapy, these patients should receive chemoprophylaxis.

PRECAUTIONS: Hormone therapy is an adjunct to, and not a replacement for, conventional therapy.

Dosage should be individualized according to the severity of the disease and the response of the patient. As soon as a satisfactory clinical response is obtained, the daily dose should be reduced, either to termination of treatment or to the minimal effective maintenance dose level. The lowest possible dose should be used and when reduction in dosage is possible, the reduction should be gradual if the drug has been administered for more than a few days. If a period of spontaneous remission occurs in a chronic condition, treatment should be discontinued.

Drug-induced secondary adrenocortical insufficiency may be minimized by gradual reduction of dosage. This type of relative insufficiency may persist for months after discontinuation of therapy; therefore, in any situation of stress occurring during that period, hormone therapy should be reinstituted. Since mineralocorticoid secretion may be impaired, salt and/or a mineralocorticoid should be administered concurrently.

There is an enhanced effect of corticosteroids on patients with hypothyroidism and in those with cirrhosis.

Corticosteroids should be used cautiously in patients with ocular herpes simplex because of possible corneal perforation.

Psychic derangements may appear or existing emotional instability or psychotic tendencies may be aggravated by corticosteroids.

Aspirin should be used cautiously in conjunction with corticosteroids in hypoprothrombinemia..

Steroids should be used with caution in nonspecific ulcerative colitis, if there is a probability of impending perforation, abscess or other pyogenic infection; diverticulitis; fresh intestinal anastomoses; active or latent peptic ulcer; renal insufficiency; hypertension; osteoporosis; and myasthenia gravis.

Growth and development of infants and children on prolonged corticosteroid therapy should be carefully observed.

Blood pressure, body weight, routine laboratory studies, including 2-hour postprandial blood glucose and serum potassium, and a chest X-ray should be obtained at regular intervals during prolonged therapy. Upper GI X-rays are desirable in patients with known or suspected peptic ulcer disease.

ADVERSE REACTIONS: Fluid and Electrolyte Disturbances. Sodium retention; fluid retention; congestive heart failure in susceptible patients; potassium loss; hypokalemic alkalosis; hypertension. **Musculoskeletal.** Muscle weakness; steroid myopathy; loss of muscle mass; osteoporosis; vertebral compression fractures; aseptic necrosis of femoral and humeral heads; pathologic fracture of long bones. **Gastrointestinal.** Peptic ulcer with possible perforation and hemorrhage; pancreatitis; abdominal distention; ulcerative esophagitis. **Dermatologic.** Impaired wound healing; thin fragile skin; petechiae and ecchymoses; facial erythema; increased sweating. May suppress reactions to skin tests. **Neurological.** Increased intracranial pressure with papilledema (pseudotumor cerebri) usually after treatment. Convulsions; vertigo; headache. **Endocrine.** Development of Cushingoid state; suppression of growth in children; secondary adrenocortical and pituitary unresponsiveness, particularly in times of stress, as in trauma, surgery or illness; menstrual irregularities; decreased carbohydrate tolerance; manifestations of latent diabetes mellitus; increased requirements for insulin or oral hypoglycemic agents in diabetics. **Ophthalmic.** Posterior subcapsular cataracts; increased intraocular pressure; glaucoma; exophthalmos. **Metabolic.** Negative nitrogen balance due to protein catabolism.

DOSAGE AND ADMINISTRATION: The initial dosage may vary from 4 to 48 mg per day. **Requirements are variable and must be individualized on the basis of the disease under treatment and the response of the patient.** The proper maintenance dosage should be determined by decreasing the initial dosage in small decrements at appropriate time intervals until the lowest dosage which will maintain an adequate clinical response is reached. If after long-term therapy the drug is to be stopped, it is recommended that it be withdrawn gradually rather than abruptly.

ALTERNATE-DAY THERAPY (ADT): ADT is a corticosteroid dosing regimen in which twice the usual daily dose of corticoid is administered every other morning. The purpose of this mode of therapy is to provide the patient requiring long-term pharmacologic dose treatment with the beneficial effects of corticoids while minimizing certain undesirable effects including pituitary-adrenal suppression, the Cushingoid state, corticoid withdrawal symptoms, and growth suppression in children.

Medrol (methylprednisolone) or other short-acting (producing adrenocortical suppression for 1¼ to 1½ days following a single dose) corticoids are recommended for ADT. Complete control of symptoms will not be possible in all patients. When considering this mode of therapy, keep in mind the basic principles and indications for corticosteroid therapy. The benefits of ADT should not encourage the indiscriminate steroids.

SUPPLIED: 2 mg—in bottles of 30 and 100 scored tablets; **4 mg**—in bott and 500 scored tablets and in 21 scored tablet Dosepak™ ; **16 mg**—in scored tablets and in 14 scored tablet ADT Pak® (formerly Alternate Day)

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nicotinic acid therapy

IMMEDIATE RELEASE		GRADUAL RELEASE
LIPO-NICIN/100 mg. Each blue tablet contains: Nicotinic Acid .....100 mg. Niacinamide ..... 75 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 5 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000	**LIPO-NICIN/250 mg.** Each yellow tablet contains: Nicotinic Acid .....250 mg. Niacinamide ..... 75 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 3 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000	**LIPO-NICIN/300 mg.** Each timed-release capsule contains: Nicotinic Acid .....300 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 3 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

WRITE FOR LITERATURE AND SAMPLES

BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th St., Los Angeles, CA 90057

REFER TO PDR

When **impotence** *due to*

androgenic deficiency

is driving them apart

Android®-5 MUQETS BUCCAL Tabs

Android®-10 ORAL Tabs

Android®-25 ORAL Tabs

Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**

REFER TO PDR

2500 West Sixth Street, Los Angeles, California 90057

MDs in the news

The National Foundation/March of Dimes has reported the following medical service grants in effect in Pennsylvania during fiscal 1974: **Marshall Klavan, M.D.,** Crozer-Chester Medical Center, Chester; **John A. Malcolm, Jr., M.D.,** and **David G. Ruschhaupt, M.D.,** Geisinger Medical Center, Danville; **Kenneth L. Fromme, M.D.,** Children's Diagnostic Center, Harrisburg Hospital; **Jeffrey M. Maisels, M.D.,** Milton S. Hershey Medical Center, Hershey; **Laird G. Jackson, M.D.,** Thomas Jefferson University Hospital, Philadelphia; **Kenneth L. Garver, M.D.,** Magee-Womens Hospital, Pittsburgh; **Louie G. Linarelli, M.D.,** Mercy Hospital, Pittsburgh; and **John J. Angelo, M.D.,** Cleft Palate Clinic of York County. Research grants were held during fiscal 1974 by the following: **Robert M. Cohn, M.D.,** and **Allen S. Goldman, M.D.,** Children's Hospital of Philadelphia; and **Philip R. Larsen, M.D.,** University of Pittsburgh.

The AMA Board of Trustees at its March meeting appointed two Pennsylvanians to committees. **William F. Kellow, M.D.,** dean of Jefferson Medical College, Thomas Jefferson University, has been named to the liaison committee on medical education. **John H. Killough, M.D., Ph.D.,** associate dean at Jefferson, will serve on the liaison committee on continuing medical education.

Harold Graff, M. D., has been appointed director of the division of psychoanalytic studies, department of research and training, Eastern Pennsylvania Psychiatric Institute. Dr. Graff's work involves the extensive collection of data through tape recording of psychoanalyses, a new process undertaken by few psychoanalysts in the country. A library of fully recorded analyses will be gathered to form a data bank of psychoanalyses.

Jeffrey I. Damsker, M.D., senior instructor in the department of radiation therapy and nuclear medicine, Hahnemann Medical College and Hospital, has been awarded a Junior Faculty Clinical Fellowship by the American Cancer Society. The program is designed to strengthen teaching programs in cancer by encouraging outstanding young clinicians to follow academic careers.

Robert L. Eisler, M.D., was recently appointed chairman of the division of mental health at the Geisinger Medical Center. Dr. Eisler was previously on the faculties of the University of Pittsburgh and the University of Hawaii Schools of Medicine.

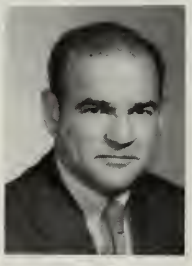
John H. Harris, Jr., M.D., became a member of the Board of Chancellors of the American College of Radiology at its recent meeting in Portland, Oregon. He will serve on the board as chairman of the Committee on Administrative Affairs and representative of the College Council. Dr. Harris has served as speaker of the ACR council for the past two years.

Jack D. Myers, M.D., professor of medicine at the University of Pittsburgh, was recently named president elect of the American College of Physicians at its annual meeting in San Francisco. Prior to his professorship at Pitt Dr. Myers had been on the faculties of Harvard Medical School, Emory University School of Medicine, and Duke University School of Medicine.

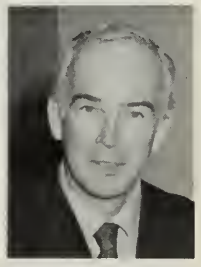
Ganesan Nagarajan, M.D., Connellsville, was recently named clinical assistant professor in the department of radiology at West Virginia University. Dr. Nagarajan is chief radiologist at Connellsville State General Hospital.

Ray F. Garman, M.D., Athens, recently received certification in the subspecialty of pulmonary diseases by the American Board of Internal Medicine.

Baruch S. Blumberg, M.D., associate director for clinical research at Philadelphia's Institute for Cancer Research, was recently elected to the National Academy of Sciences. He has received worldwide recognition for his discovery of the Australia antigen, a protein particle that permits detection of the hepatitis B virus in the human bloodstream. He recently announced evidence that infection with this virus leads to hepatoma. A vaccine for hepatitis is now in development and may prove to be the first vaccine to prevent a human cancer.



DR. BLUMBERG



DR. SLATER

Robert J. Slater, M.D., president of the Medical College of Pennsylvania, has accepted the invitation of the National Research Council's Commission on Human Resources to serve on its Committee on the Education and Employment of Women in Science and Engineering.

State Secretary of Welfare Frank S. Beal recently named **John K. Fong, M.D.,** Newtown, as superintendent of the Haverford State Hospital. Dr. Fong was previously acting director of the hospital.

Steven M. Greenwood, M.D., was recently made an associate in the division of laboratory medicine at the Geisinger Medical Center, Danville.

The American College of Radiology recently named **George R. Matthews, M.D.,** Reading, **John B. Cooley, M.D.,** Conneaut Lake, and **Geno J. Di Bagno, M.D.,** Greensburg, as fellows.

MDs in the news

Three physicians at York Hospital, York, have recently made accomplishments within their specialties. **William O. Rexrode, M.D.,** director of the pulmonary services department, has passed the subspecialty examination in pulmonary disease given by the American Board of Internal Medicine. **Stanley D. Freedman, M.D.,** an internist, has been certified in the subspecialty of infectious disease. **C. Edwin Martin, M.D.,** associate director of the cardiac diagnostic laboratory, was installed as a fellow of the American College of Cardiology.

DR. REXRODE

DR. FREEDMAN

DR. MARTIN

DR. POINSARD

The American Heart Association recently gave the Established Investigator Award to two Temple University faculty members. **Alfred Bove, M.D.,** will study how the heart enlarges and fails when it is overloaded for extended periods of time. **Holm Holmsen, Ph.D.,** of Temple's Thrombosis Research Center, will study how the metabolism of chemical energy in adenine nucleotides is linked to the function of platelets. Each researcher will receive about $80,000 over five years.

The American College of Physicans recently elected **James J. Houser, M.D.,** Franklin, to fellowship. Dr. Houser was inducted during the convocation in San Francisco early in April.

Amanda C. Blount, D.O., in the department of medicine at the Albert Einstein Medical Center, Daroff Division, is currently serving as chairwoman of the Committee on Community Health Education of the Advisory Council for Comprehensive Health Planning, Pennsylvania Department of Health.

Paul J. Poinsard, M. D., professor of psychiatry and human behavior at Jefferson Medical College, was elected recently as president of Jefferson's Voluntary Faculty Association. The association was established in 1970 to help fulfill the goals of the medical college and maintain the highest standards of patient care at Thomas Jefferson University Hospital.

Frederick B. Wagner, Jr., M.D., Penn Valley, was recently elected president of the Alumni Association of Jefferson Medical College, Thomas Jefferson University. Dr. Wagner is a former director of surgery at William B. Kessler Memorial Hospital, Hammonton, N.J., and a founding member of the American College of Angiology.

A scientific exhibit entitled "Beta Blockers in the Management of Angina and Arrhythmias" was presented at the annual meeting of the American College of Physicians in San Francisco by **Eugene Coodley, M.D., F.A.C.P., Stuart Snyder, M.D.,** and **Krishan Bharadwaja, M.D.,** from the department of medicine at Hahnemann Medical College and Hospital. Dr. Coodley is professor and associate chairman in the department.

The American Board of Family Practice recently named the following as diplomates: **Preston Erway, M.D.,** Wellsboro; **Frank O'Neil Robertson, M.D.,** Ford City; **Thomas J. Kardish, M.D.,** Churchville; **James W. Montague, M.D.,** Blossburg; **M.B.S. DeSilva, M.D.,** Blossburg; **Ronald E. Hinebaugh, M.D.,** Monongahela, **Jack A. Marshall, M.D.,** Erie, and **Neal Van Marter, M.D.,** Erie.

Jonathan L. Stolz, M.D., Birdsboro, was elected to the board of the Daniel Boone National Foundation recently. Dr. Stolz is editor of the Berks County Medical Society's publication, *The Medical Record.*

Abol H. Pourhamidi, M.D., Jeannette, recently became a fellow of the American College of Chest Physicians.

Frank D. Geer, M.D., New Castle, was recently elected president of the Western Pennsylvania Psychiatric Association for a two year term. In the past he has served as secretary treasurer and vice president of the association and president of the Lawrence County Medical Society.

Andrew H. Hefferman, M.D., Allentown, was recently appointed deputy director of the Lehigh County Civil Defense medical division. His responsibilities will include liaison with subdivision medical and health staff groups in the county, and general coordination of disaster operations carried out by local health units.

Louis G. Fetterman, M.D., Palmyra, was recently appointed medical director of two nursing homes, the Camp-A-While Nursing Home, Campbelltown, and the Palmyra Nursing Home.

The community of Brockway recently honored **N. F. Lorenzo, M.D.,** and **A. E. Devlin, M.D.,** the town's only general practitioners. Drs. Lorenzo and Devlin each have practiced in Brockway for over 25 years.

MDs in the news

Your man in Lemoyne

Kenneth L. Cooper M.D.—Seventh District

DONNA WENGER
Communications Division

A native of New Jersey, Kenneth L. Cooper, M.D., chose to practice in the Williamsport area of Pennsylvania because it was his wife's home. His choice of specialty, obstetrics and gynecology, reflects another influence in his life. "In medical school, the instructors in the field of obstetrics and gynecology were particularly inspiring and their courses were very good. Consequently, my specialty choice was logical—combining my interest in surgery and obstetrics."

With premedical education from Marysville College, in Tennessee, completed in 1943, Dr. Cooper interrupted his educational career for a two year stint in the Army. Five years later, with his medical school training completed in 1950 at Temple University School of Medicine, he interned at the same institution.

When his residency at Temple was completed in 1954, he settled in Williamsport and began his private practice in obstetrics and gynecology. He soon joined several other young doctors to form a group practice. Board certified in 1958, he is affiliated with the Williamsport Hospital where he is chairman of the department of obstetrics and gynecology. He is on the medical staff at Divine Providence Hospital, Williamsport, and on the consulting staff at Soldiers and Sailors Hospital, Wellsboro.

Dr. Cooper's initial involvement with organized medicine was his joining the Lycoming County Medical Society. After serving as secretary for his county medical society for five years, he was elected to its board of directors in 1972.

In 1966 he was appointed to the Council on Public Service, thus beginning his activities with the State Society. A member of that council for six years and chairman his last two years, Dr. Cooper has also been active in various committees at the state level including the Benjamin Rush Awards Committee and the recent ad hoc committee to study unions. A recent member of the Publications Committee, he is currently on the Finance Committee and has just been named a member of the Co-op Board. In 1972 he was elected trustee of the Seventh Councilor District.

While Dr. Cooper has expressed interest in various community activities, he has been most involved with community health education, particularly sex education and cancer screening. To that end, he has been instrumental in educating such groups as parent teacher organizations. With the help of three members of the obstetrics staff of Williamsport Hospital, he established a family planning clinic three years ago. It serves as an extension of his concern for public education on human sexuality. He currently serves on the local

school board's curriculum committee on sex education. The goal, he says, "is to formulate some meaningful curriculum for the grade and high school children of our area. We want a quality program to inform young people about various aspects of sexuality."

Another extension of this concern for adequate public education is manifested in Dr. Cooper's involvement in screening clinics for the early detection of cancer. "It is vitally important for women to learn the technique of self-examination of breasts. I am personally committed to a decrease by 50 percent in the mortality rate from breast and uterine cancer within the next ten years." For the American Cancer Society, Dr. Cooper has served as president and crusade chairman of the Lycoming County branch.

Dr. Cooper reflected on another aspect of his total concern for quality education: "I suppose one of my greatest concerns is for the future of medicine and the availability of quality medical education. Over the past five years, the situation seems not to have changed. We still have problems with the number of available positions in med school; enrollment has not increased. Yet we do need more physician manpower. I feel we could better utilize our schools, and at the same time teach our students, if we would put third and fourth year students directly into hospitals. That would allow more space for new students, and simultaneously give live schooling to our advanced students."

Your man in Lemoyne

David J. Keck, M.D.—Eighth District

Dr. David J. Keck says of his tenure as trustee and councilor of the Eighth District, "I wouldn't trade the experience for anything. It's been both an education and a means of service at the same time."

As are his colleagues on the Board, Dr. Keck has been spending considerable time in recent months on the malpractice crisis, and in addition to attending meetings in Lemoyne and conducting them in the district, has appeared on behalf of the Society to explain the issues to interested groups.

Dave Keck was born in Butler, April 29, 1925, and completed his undergraduate studies at Capital University in Columbus, Ohio. He received his degree in medicine from Jefferson Medical College in 1949.

Internship took him to St. Vincent Hospital, Erie, and he has had close ties with that institution ever since. He lives in Fairview, just outside Erie, and maintains an office for private general practice there.

Dr. Keck served the Erie County Medical Society as its president in 1971, culminating a long period of activity at the county society level. He held a number of elected offices and served as county society delegate to the State Society's House of Delegates for 12 years prior to his election as trustee to fill the unexpired term of the late James Biggins. In 1971 he was elected to his first full term on the Board, representing the counties of Crawford, Erie, Forest, McKean, Mercer, and Warren.

Currently Dr. Keck is chairman of the Publication Committee and of the ad hoc committee to evaluate planning, whose report will be considered at a special Board meeting in July. He is Board representative to the Council on Professional Relations and Services. In previous years he served on the Committee on Family Practice and the Officers' Conference Committee, and as an alternate delegate to the AMA.

Dr. Keck, in addition to his private practice, is medical director of St. Vincent Hospital's Alcoholism Program and Detoxification Center—a program he helped to establish 24 years ago. The center is considered a model and now includes a 16 bed inpatient unit. Admissions number over 700 a year, and require outpatient followup, including work with Alcoholics Anonymous, Crossroads, Inc. (a halfway house), and group therapy. Dr. Keck directs these activities and sees eight to ten patients a week in private followup visits.

He serves the Erie County Hospital as medical director. This intermediate care facility has a patient load of 550, a medical staff of six, and plans for a $20 million expansion.

Dave Keck has won the respect of his colleagues

Drs. Keck and Clare concentrate on Board business at a recent meeting.

in Erie for his work with the Alcoholism Program and most of his other community activities relate to his service in this area. These include membership on the governing boards of the Erie County Council on Alcoholism and "Family Crisis." He admits that his greatest professional satisfaction has come from "taking care of people in my practice and from working with the Alcoholism Program."

Dave Keck is a strong supporter of the Pennsylvania Medical Political Action Committee as a means to effective improvement in government. His hobbies are golf and his home in Florida—when he has time to use it.

Medical expert's testimony stands up in court

DANIEL J. MENNITI, Ph.D., J.D.
Harrisburg

The author is associated with the law firm of Pepper, Hamilton, and Scheetz, which provides legal counsel to the State Society.

Relying heavily on psychiatric testimony, the Commonwealth Court[1] has upheld the award of lifetime workmen's compensation benefits to a murdered girl's mother.

Debbie was a 19 year old sales clerk at a Scranton department store. David was employed as a stock clerk. One day, without provocation but under delusions that she had failed to keep dates with him, David stabbed Debbie 13 times in full view of customers and other employees. Debbie was pronounced dead one hour later at a hospital. David was committed to a hospital for the criminally insane after psychiatric examination. Debbie's mother filed for workmen's compensation benefits.

Under the Workmen's Compensation law[2] if the death occurred in the course of employment the survivors could recover. If, however, the death was caused "because of reasons personal to" the assailant, there could be no recovery. The employer argued that the law precluded any benefits from workmen's compensation for Debbie's survivors because the victim was attacked for reasons personal to the assailant.

The Court, however, looked to the factual situation and found that there was no "acrimonious relationship between Debbie and her assailant prior to the assault." It is noteworthy that the Court relied heavily on psychiatric testimony:

> All of Evans' reasons for his conduct were the result of his schizophrenic paranoid mental illness. The report of one of the psychiatrists, which is part of the record, establishes that Evans could not have had any *personal* reason directed toward *Debbie* at the time of the attack. In Evans' words, recorded by psychiatrist who examined him: "I guess it could have been anybody."

On the basis of this evidence in the record, the Court held that Debbie's death was compensable because her attack was "completely psychotic, uncontrolled, homicidal furor, and rage."

The Court stated that this case presented a novel legal situation and, therefore, did not rely on the cases cited by either side because "none of the cases cited by either of the parties in this appeal relates to an unprovoked injury or death inflicted by an insane, irrational fellow employee." Citing a Pennsylvania Supreme Court decision,[3] the Court held that the burden of proving the intention to injure for reasons personal to an assailant is the burden of the employer. The Court also concluded that there had to be some intention on the part of the assailant to inflict the injury for "personal reasons." Moreover, the Court noted that the Workmen's Compensation Act is "remedial in nature and, therefore, should be liberally construed in favor of the employee." These facts were coupled with the decision of an old case of the Pennsylvania Supreme Court, *O'Rourke vs. O'Rourke*[4] which concerned an intoxicated assailant. The Supreme Court had held that the fact of intoxication showed that there was no personal animosity between the assailant and the employee. The Commonwealth Court reasoned that there was little difference between the result in this case where the assailant was an insane employee unable to distinguish right from wrong, and the result in the *O'Rourke* case, where the assailant was intoxicated and "with a similar mental condition at the time of the attack."

Although psychiatrists may be tempted to disagree with the conclusion concerning the similarity of the effects of intoxication and the effects of a psychosis, they should take heart in the weight given to expert psychiatric testimony.

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[1] *Cleland Simpson Co. & Pennsylvania Manufacturers' Association Insurance Co. vs. Workmen's Compensation Appeal Board & Rose Marie McLaughlin, Commonwealth Court (February 25, 1975).*

[2] 77 P.S. §1 *et seq.*

[3] *Dolan vs. Linton's Lunch,* 397 Pa. 114 (1959).

[4] 278 Pa. 52 (1923).

editorials

More on That #*X%?&! PRA

June 30, 1975, was to have been the cut off date for Pennsylvania physicians to qualify for the American Medical Association Physician's Recognition Award. However, in recent board action, this date has been extended one year. Physicians must now qualify for the award by June 30, 1976, to remain members in good standing of the Pennsylvania Medical Society.

There have been several major changes in the recent months which alter considerably the continuing medical education membership requirements and the nature of the award. The three year waiting period has been eliminated by the American Medical Association. A physician may now submit an application at any time that he has accumulated the necessary number of credit hours with at least 60 in Category I. The official AMA form may be used or a simplified substitute offered by the Society. A reproduction was printed in the February 1975 issue of PENNSYLVANIA MEDICINE.

New also is the waiver of continuing medical education requirement. Physicians may apply for exemption from the continuing education requirement on either a permanent or temporary basis under the following conditions. A total permanent waiver may be applied for if the physician is completely retired. A limited time waiver may be applied for if the physician is temporarily prevented from practicing due to illness, disability, etc., and extensions may be granted for periods of one year to unlimited. A conditional waiver is provided for physicians who are not able to meet the PRA requirements but who can provide evidence that they have sought and achieved other ways of keeping current. Appropriate examples would be that of a pathologist at a university center who is primarily engaged in research or an elderly rural physician who engages in home study programs to learn of advancements in medicine applicable to his practice.

Both the date change and waivers are intended to aid Pennsylvania physicians. The continuing medical education requirement was not and is not intended to be punitive. It is a method by which we can give assurance to the public that the Pennsylvania Medical Society and its membership is making every effort to maintain and deliver the highest quality of medical care available to our patients.

David A. Smith, M.D.
Medical Editor

Our most serious health problem

Our nation is gradually becoming aware that alcoholism may be its most serious health problem. It differs from other illnesses because not only is the health of the afflicted disturbed, but it is a disorder that seriously disturbs the lives of all members of the constellation in which the sick one functions. It causes serious emotional and mental problems that may handicap them all their lives. The exact number of persons suffering from the sickness of alcoholism is not known but ten million is regarded as a reasonable estimate and since five or six other million may be affected by the alcoholic, the mental health of many millions may be seriously disturbed.

Much is written about what causes persons to become alcoholic and pre-existing personality organization is commonly discussed. We know that in most diseases some receptivity in the individual exists which permits the specific causative agent to afflict some while others exposed do not become ill. The tubercle bacillus is the specific causative agent of tuberculosis and the *specific cause of alcoholism is alcohol.* It possesses addictive properties which may insidiously cause the disease.

It is unlikely that there is an absolute immunity to any illness and massive and continuous exposure to a disease agent may eventually cause the activation of the disorder. Physicians do not have an endowed immunity to disease and certainly not to the illness of alcoholism, yet there is such consistent exposure of physicians to occasions for having a drink that alcohol addiction is gradually becoming recognized as a serious occupational hazard.

It is probably the oldest tranquilizer (all tranquilizers are habituating) and a cocktail or highball is looked upon as an excellent way to unwind after a tough day. At every social event there is almost an explicit expectation that you will have a sociable drink. The club is a place where conviviality seems to demand a drink. There are few

medical gatherings where alcohol before, during, and after does not play a part. Recently I learned of a hospital where the director has established a cocktail hour for interns and residents as a means of improving morale. It is questionable how much it contributes to improve patient care.

In our ranks there are many who have a drinking problem and in these days when the quality of medical care is under consumer scrutiny the effects of alcohol are being considered and will be more significant in PSRO deliberations as well as by lawyers in malpractice suits.

Industry now sets up programs for the rehabilitation of employes with a drinking problem and it is time we begin arranging for the care of our members who have a drinking problem. Let the program begin with you.

Samuel B. Hadden, M.D.
Contributing Editor
Philadelphia

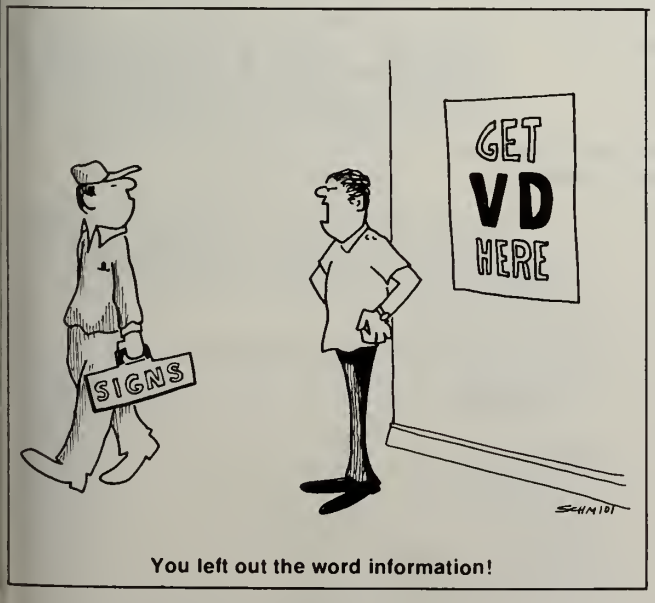
in my opinion

The most competent care

A recent pronouncement from the Chicago headquarters of the American College of Surgeons followed the pattern of many similar statements in the past. It repeated the opinion that surgery should be done only by those who are specifically trained to do it. All knife privileges should be limited to diplomates of the Board of Surgery or members of the American College of Surgeons.

Some capable surgeons simply do not fulfill these qualifications. There will also be some instances where it would have been better had the requirements been met. On the whole, I think this point is well taken. In the future, surgical procedures will be done more and more by those who are particularly trained for them.

In the light of this, it surprises me that some medical leaders are expounding the capabilities of physicians who are inadequately trained to do family practice. There is a shortage of family physicians and it is often necessary for others to perform these highly technical duties even though they are not well prepared. Just as a doctor with little training or experience may sometimes have to do an emergency appendectomy, so it sometimes will be necessary for a urologist or even an endocrinologist to do primary and even family care in the absence of a specialist in the field. It upsets me thus that prestigious people in the medical profession are scrambling to get governmental moneys currently available for the training of primary physicians when these people have no intention of training students to perform that medical specialty as effectively and skillfully as it should be done.



You left out the word information!

Under pressures from medical educators and particularly the Association of American Medical Colleges, the definition of primary care has been broadened to include internal medicine, pediatrics, and obstetrics and gynecology in addition to family practice. Of these, the pediatrician has perhaps the next best claim but he limits his practice to one age group and is very reluctant to do even the most minor surgery. The internist is by definition a specialist in depth and today the general internist is actually following in the footsteps of the "horse and buggy" doctor who has been lamented so much. The subspecialists dig their narrow holes so much deeper. The general internist today is in between, neither deep enough nor broad enough. If internists and pediatricians want to train doctors to do primary care and handle the comprehensive care of families, they have no choice but to train them in the same way that family medical specialists are trained. If they go deeply into the fields of internal medicine or pediatrics, they will find themselves lacking in the broad aspects that give the family doctor his comprehensive approach to any problem that confronts him.

With no disrespect for the OB-GYN man, his inclusion as a primary physician is a political maneuver. This is like including the neurosurgeon in the list because a headache patient may sometimes

correctly determine he has a brain tumor and, therefore, consult such a specialist first.

If we agree that open heart surgery should be the domain of the cardiac surgeon and that other intricate and complex procedures should be restricted to those who have the necessary special training, our course should be clear. Medicine as a whole, and medical educators in particular, should recognize that primary comprehensive medical care should be left to him who best understands it, the family physician.

All efforts should be applied to correcting the serious shortage that presently exists. Just as it is not an optimal procedure to give a young medical graduate six months experience in the operating room and then send him out to do a full range of surgery, neither is it the best choice to train a man to be a consultant in any field of medicine and then give him a smattering of the other disciplines and expect him to be an efficient family physician.

George A. Rowland, M.D.
Guest Editor
Millville

State's approved dialysis centers listed

Continued from page 10

Bio-Medical Applications of Allentown, Inc.
2015 Hamilton Street
Allentown, PA 18102
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Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has existing disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Hertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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(Continued on page 36)

PROLOID® (thyroglobulin)
Caution: Federal law prohibits dispensing witho prescription.
Description. Proloid (thyroglobulin) is obtaine from a purified extract of frozen hog thyroid. It cor tains the known calorigenically active component Sodium Levothyroxine (T_4) and Sodium Liothyr nine (T_3). Proloid (thyroglobulin) conforms to th primary USP specifications for desiccated thyroid for iodine based on chemical assay—and is als biologically assayed and standardized in animal
Chromatographic analysis to standardize the S dium Levothyroxine and Sodium Liothyronine co tent of Proloid (thyroglobulin) is routinely employe
The ratio of T_4 and T_3 in Proloid (thyroglobulin is approximately 2.5 to 1.
Proloid (thyroglobulin) is stable when stored usual room temperature.
Indications. Proloid (thyroglobulin) is thyroid r placement therapy for conditions of inadequate e dogenous thyroid production: e.g., cretinism an myxedema. Replacement therapy will be effecti only in manifestations of hypothyroidism.
In simple (nontoxic) goiter, Proloid (thyroglob lin) may be tried therapeutically, in nonemergen situations, in an attempt to reduce the size of suc goiters.
Contraindication. Thyroid preparations are contr indicated in the presence of uncorrected adren insufficiency.
Warnings. Thyroglobulin should not be used in th presence of cardiovascular disease unless thyroi replacement therapy is clearly indicated. If the la ter exists, low doses should be instituted beginnin at 0.5 to 1.0 grain (32 to 64 mg) and increased the same amount in increments at two-week inte vals. This demands careful clinical judgment.
Morphologic hypogonadism and nephrose should be ruled out before the drug is adminis tered. If hypopituitarism is present, the adrenal d ficiency must be corrected prior to starting the dru
Myxedematous patients are very sensitive to th roid and dosage should be started at a very lo level and increased gradually.
Precaution. As with all thyroid preparations th drug will alter results of thyroid function tests.
Adverse Reactions. Overdosage or too rapid i crease in dosage may result in signs and symptom of hyperthyroidism, such as menstrual irregular ties, nervousness, cardiac arrhythmias, and angin pectoris.
Dosage and Administration. Optimal dosage usually determined by the patient's clinical r sponse. Confirmatory tests include BMR, T_3[13 resin sponge uptake, T_3[131]I red cell uptake, Thy Binding Index (TBI), and Achilles Tendon Refl Test. Clinical experience has shown that a norm PBI (3.5-8 mcg/100 ml) will be obtained in patient made clinically euthyroid when the content of T and T_3 is adequate. Dosage should be started small amounts and increased gradually with incr ments at intervals of one to two weeks. Usual mai tenance dose is 0.5 to 3.0 grains (32 to 190 m daily.
Instructions for Use. The following conversio table lists the approximate equivalents of oth thyroid preparations to Proloid (thyroglobulin) whe changing medication from desiccated thyroid, T (sodium levothyroxine), T_3 (sodium liothyronine), T_4/T_3 (liotrix).

CONVERSION TABLE

Dose of Proloid (thyroglobulin)	Dose of Desiccated Thyroid	Dose of T_4 (sodium levothyroxine)	Dose of T_3 (sodium liothyronine)	Dose of liotrix (T_4/T_3)
1 grain	1 grain	0.1 mg	25 mcg	#1 (60 mcg/15 m
2 grains	2 grains	0.2 mg	50 mcg	#2 (120 mcg/30 m
3 grains	3 grains	0.3 mg	75 mcg	#3 (180 mcg/45 m
4 grains	4 grains	0.4 mg	100 mcg	
5 grains	5 grains	0.5 mg	125 mcg	

In changing from Thyroid USP to Proloid (thyr globulin), substitute the equivalent dose of Proloi (thyroglobulin). Each patient may still require fin adjustment of dosage because the equivalents a only estimates.
Overdosage Symptoms. Headache, instability nervousness, sweating, tachycardia, with unusu bowel motility. Angina pectoris or congestive hea failure may be induced or aggravated. Shock ma develop. Massive overdosage may result in symp toms resembling thyroid storm. Chronic excessiv dosage will produce the signs and symptoms hyperthyroidism.
(Treatment: In shock, supportive measures shoul be utilized. Treatment of unrecognized adrenal i sufficiency should be considered.)
Supplied. ¼ grain tablets in bottles of 100 (N 004 0250-51) and 1000 (N 0047-0250-60); ½ grain tab lets in bottles of 100 (N 0047-0251-51) and 1000 (0047-0251-60); scored 1 grain tablets in bottles 100 (N 0047-0252-51) and 1000 (N 0047-0252-60 1½ grain tablets in bottles of 100 (N 0047-0253-5 and 1000 (N 0047-0253-60); scored 2 grain tablet in bottles of 100 (N 0047-0257-51); 3 grain tablet in bottles of 100 (N 0047-0254-51) and 1000 (0047-0254-60); scored 5 grain tablets in bottles 100 (N 0047-0255-51) and 1000 (N 0047-0255-60 Full information is available on request. P-GP-51 4/
WARNER/CHILCOTT
Division, Warner-Lambert Company
Morris Plains, N.J. 07950

Improving on nature... from the rough, uncut stone to the finished gem

In thyroid therapy, too... all the qualities of the "natural" with the added improvements of man...

Proloid®
(thyroglobulin)

natural thyroid...but uniquely purified
Devoid of any glandular debris.

natural thyroid...but triply standardized
Standardized chemically, biologically, and (at intervals) clinically, for consistent metabolic activity from batch to batch.

natural thyroid...but consistently fresh
Potency undiminished for up to 4 years under proper storage conditions.

It all adds up to natural thyroid with the added improvements of man.

Please see adjoining column for brief summary of prescribing information.

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(Continued from page 34)

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Pro-Banthine®
brand of
propantheline bromide

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to: G. D. Searle & Co.
Medical Department, Box 5110, Chicago, Ill. 60680 481

"Antiacid" action for ulcer patients...

one of the many things you need in an anticholinergic.

Pro-Banthine is considered adjunctive in total peptic ulcer therapy that may include diet, conventional antacids, bed rest, and other supportive measures.

Pro-Banthine is provided in several different dosage forms which will meet virtually any clinical need. It is just as versatile in filling patient needs, among which are:

"Antiacid" action—Pro-Banthine® (propantheline bromide) reduces gastric secretory volume and resting total and free acid.

"Analgesic" action—Pro-Banthine helps to control the acid-spasm-pain complex.

Vigorous anticholinergic action—Pro-Banthine® Vials, 30 mg., are for intramuscular or intravenous use when prompt and vigorous anticholinergic action is required.

Mild anticholinergic action—Pro-Banthine® Half Strength, 7.5 mg. tablets, for more exact adjustment of maintenance dosage in mild to moderate gastrointestinal disorders.

Pro-Banthine®
(propantheline bromide)

a good option in peptic ulcer

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

makes sense in edema.*

Neither inconvenient, unpalatable, expensive potassium supplements nor special K^+ rich diets are needed as a rule. Just 'Dyazide' once or twice daily for control of edema. Serum K^+ and BUN should be checked periodically (see Warnings section).

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

WARNING
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. **Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

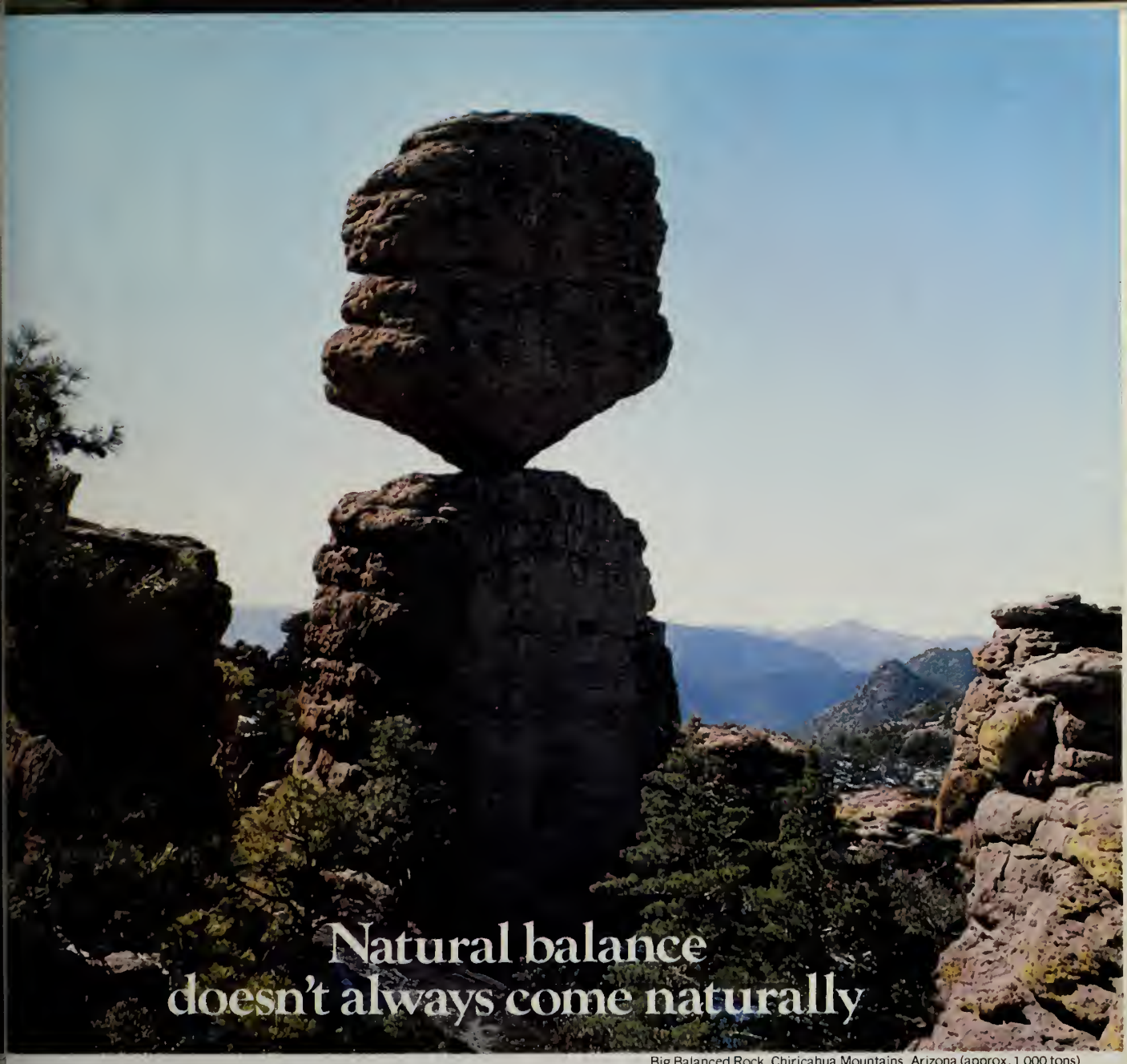
Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

'Dyazide' gets excess water and salt out and helps keep essential potassium in.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

und useful in the management of vertigo* associated with
ses affecting the vestibular system.
n relieve nausea and vomiting often associated with vertigo.*
ual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.
so available as Antivert (meclizine HCl) 12.5 mg. scored
ts, for dosage convenience and flexibility.
ntivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for
ea, vomiting and dizziness associated with motion sickness.

SUMMARY OF PRESCRIBING INFORMATION

DICATIONS. Based on a review of this drug by the National Academy of nces—National Research Council and/or other information, FDA has classified ndications as follows:
fective: Management of nausea and vomiting and dizziness associated with on sickness.
ssibly Effective: Management of vertigo associated with diseases affecting the bular system.
nal classification of the less than effective indications requires further stigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

PAIN RELIEF FOR THE MAJORITY

NO.4—for pain intensity below the need for injectables

As a rule, only pain that requires morphine is beyond the scope of Empirin® Compound with Codeine No. 4. That's because it delivers a full grain of codeine. (In the preferred phosphate form.) Its antitussive action is particularly appreciated by patients with fractured ribs, and following chest or abdominal surgery. Its low addiction liability is a bonus for all patients who require potent analgesia.

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Most other kinds of lesser pain respond to Empirin Compound with Codeine No. 3—whether musculoskeletal, neurological, soft-tissue or visceral. One might say No. 3 is an "all-purpose" analgesic — not too little, not too much. Just right for your out-patients in these categories.

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*Warning—may be habit-forming.

Each tablet also contains aspirin gr 3½, phenacetin gr 2½, caffeine gr ½.

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- **more effective**—49% more acid neutralizing capacity than the next leading antacid.*
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*per minimum recommended dose.

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One contains aspirin. One doesn't.

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100 mg. propoxyphene napsylate and 650 mg. acetaminophen

Darvon® Compound-65
65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine

Lilly

Additional information available to the profession on request.
Eli Lilly and Company, Inc., Indianapolis, Indiana 46206

500341

Whither PSRO—1975

MATTHEW MARSHALL, JR., M.D.
Pittsburgh

Last year I reviewed the Foundation's concerns related to the lack of progress in implementing PSRO due to bureaucratic delays and turf protecting impulses of other organizations. I expressed concern that only with proper physician guidance could bureaucratic strangulation of the program be avoided.

Today, I can report that there has been progress despite the continuing existence of a multitude of problems and barriers to the orderly implementation of the law. Progress can be directly attributed to Pennsylvania physicians who have taken the leadership and had the patience to guide the program. Last year, I could report only one PSRO contract. That was the Statewide PSRO Support Center Contract awarded to the Foundation. HEW designated the Foundation as the Nation's first support center responsible for assisting physician groups in the organization and operation of PSROs in accordance with the actions of the June, 1973 special session of the PMS House of Delegates. Support centers were not specified in the law, but Senator Bennett declared the House of Delegates' action consistent with the legislation and hence support centers were born. It is highly unlikely that we will ever see an action of the House of Delegates so directly translated into federal regulations.

During the summer of 1974, eight of the twelve PSROs in Pennsylvania were awarded HEW contracts to plan a PSRO:

(a) The Central Pennsylvania Area II PSRO, chaired by C. Jack Rodgers, M.D., Williamsport, is presently working on a conditional proposal which could be approved during the next fiscal year, which begins July 1, 1975.

(b) The Eastern Pennsylvania Health Care Foundation, chaired by David A. Tilly, M.D., Allentown, has submitted a conditional proposal to HEW and will likely be considered for conditional status in the next fiscal year—after July 1, 1975.

(c) The Allegheny PSRO, chaired by James R. Dornenburg, M.D., Pittsburgh, has been tentatively approved by HEW and should be designated conditional status in June or July of this year.

(d) The Southwestern Pennsylvania PSRO, chaired by Donald C. Brown, M.D., Greensburg, has submitted a conditional proposal to HEW. Negotiations are continuing and the PSRO might be designated conditional status in June or July.

(e) The Highlands PSRO, chaired by Thomas Skrentny, M.D., Altoona, has submitted a conditional proposal to HEW, but it is not final at this time. It will likely be considered for conditional status in the next fiscal year—after July 1, 1975.

(f) The Southcentral Pennsylvania PSRO, chaired by James Z. Appel, M.D., Lancaster, has tentatively been approved by HEW for conditional designation in June or July.

(g) The Montgomery/Bucks PSRO, chaired by John L. Steigerwalt, M.D., Rosemont, is awaiting final approval of its conditional proposal and hopes to be funded this fiscal year—prior to July 1, 1975.

Dr. Marshall, Pittsburgh urologist, is a member of the Council on Medical Service and president of the Pennsylvania Medical Care Foundation. This paper was presented at the 1975 Officers' Conference.

(h) The Philadelphia PSRO, chaired by Sidney O. Krasnoff, M.D., Philadelphia, has submitted a conditional proposal to HEW. Negotiations are continuing, with possibility of approval this fiscal year.

In addition, the Area I PSRO, chaired by Robert Stuart, M.D., of Erie, and the Area V PSRO, chaired by Raymond Saloom, D.O., of Harrisville, have submitted proposals for planning contracts to HEW. The Northeastern Pennsylvania PSRO, chaired by Edwin Neville, M.D., of Scranton, has completed a proposal which has not yet been submitted. Although physicians in the PSRO Area X (Delaware and Chester Counties) have not set up a PSRO, the Delaware County Medical Society recently took action to assist in organizing a PSRO committee of physician volunteers.

The process of organizing PSROs has created frustrating experiences for physicians in such things as bylaw provisions, election procedures, reimbursement policy for physicians and board composition. Assurance of geographic and osteopathic representation on PSRO boards has been a troublesome issue because of

the literal interpretation of the law by HEW guaranteeing one man one vote and equal opportunity to serve on the board. The concept of a nonprofit organization responsible for peer review, as advanced by the AMA, was accepted by Congress in the PSRO legislation, but modified to the extent that these organizations must be open to all physicians without payment of dues. With this historical background, HEW has held that policymaking functions of PSRO boards, like county society and other nonprofit organizations, are not compensable activities. Some physicians have felt that all PSRO activities should be reimbursable. Of course, from the outset, the Foundation's Board has not been reimbursed for such functions. I believe that it is likely that physicians will be reimbursed for only those activities related to the operational functions of PSROs. Moreover, it appears that PSROs will need to generate some income from voluntary dues and other sources to support activities considered desirable but not within the scope of the HEW PSRO Contract.

In discussing the problems of PSRO implementation, we must keep in mind that this is the first authority for physicians in local areas to assume responsibility formerly delegated to Blue Cross and medicaid. Therefore, PSROs are now enjoying the blessings of dealing with the federal government, which was formerly reserved for Blue Cross, medicaid, and hospital administrators. The real battle is to assure that the physician who usually properly admits, treats, and discharges his patient is not harassed and, indeed, he should hardly know a peer review system is in effect. Better patient care, rather than better paper generation, is the goal. We have held that only a physician controlled organization can assure that these objectives are not forgotten.

There is continuing indication, both at the national and state levels, that governmental agencies are not fully committed to the PSRO intent to transfer review authority to PSROs. In Pennsylvania, the PSROs, working through the Foundation's PSRO Development Committee, chaired by Sidney O. Krasnoff, M.D., of Philadelphia, are attempting to develop a Memorandum of Understanding to provide for an orderly transfer of review responsibility for medicare and medicaid. To date, progress has been slow and there is no clear indication that state government is willing to voluntarily delegate to PSROs the type of review authority intended by Congress. For example, on February 1, 1975, DPW instituted a contract with PAID Prescriptions, a California based, nonprofit corporation, to process medicaid drug bills and develop a peer review system in twelve review areas with different boundaries than PSROs. If transfer of authority, or real cooperation, was intended, it seems incredible that neither the Foundation, PSROs, nor the Pennsylvania Medical Society were informed during the three months of implementation of the program.

PSRO problems are not limited to governmental agencies. The problems with the Joint Commission on Accreditation of Hospitals (JCAH) are indeed ironic since it is a voluntary organization considered closely related with organized medicine. Cooperation with physician organizations is expected. However, the JCAH has not provided the Pennsylvania Medical Society or the Foundation the opportunity afforded by HEW to comment on their regulations prior to their implementation. For example, JCAH insistence on multiple medical audit studies following its time consuming methodology may well encourage the opportunities for malpractice activity by placing physicians in a dilemma of either neglecting prescribed quality assurance tasks in the hospitals or their patients. Moreover, the announced intention of JCAH to cooperate with PSRO programs has not resulted in a response to repeated Foundation inquiries dating back to January, 1974.

PSRO is the eye of a storm and the struggle for control of power and money in health care. It is a complex law and its intent has been confused both by an excess of political infighting for power at all levels and multiple side issues. For example, I believe it will be unlikely that the Foundation Board or the PSROs will be satisfied with proposed regulations regarding confidentiality. Moreover, it has been proposed that PSROs be given authority to evaluate malpractice claims. PSRO activities are not the forum for adversary proceedings. If physicians cannot operate their review processes freed of cumbersome formal legal procedures or are under threat of stimulating frivolous suits, the benefit to the public of PSRO review will be destroyed.

Critics of PSRO, within our ranks, may distract you from recognizing those areas where there is commonality of PSRO objectives with the enlightened self-interest of physicians. Critics of PSRO, from consumer ranks, calling for more punishment of physicians, distract from the recognition that better patient care is the real objective in their self interest. I hope you will all recognize the candor in the statement of Mr. Thomas Tierney, director of medicare, which stated, in effect, that regardless of what programs are repealed or replaced, there will be a program to watch the government's health care programs and programs to watch the watchers.

I hope you will recognize that if decisions regarding appropriate care and approval for payment on the basis of necessity is in the hands of local physicians, it will require organization, staff, adequate funding, and complete authority from the government, as provided in the PSRO legislation, to carry out its purpose.

Politics makes strange bedfellows. Paradoxically, opposition to the concept of PSRO comes from the Council on Medical Staffs organization, consumer advocates, and the medicaid program since these interests advocate that decisions regarding payment for medical services should rest in the hands of an organization not responsible to the local physician community. There will be no lack of organizations willing to perform PSRO functions.

In closing, I trust you recognize that, in asking you to support PSRO, I am not promising you a rose garden, only an opportunity to stay in the arena where decisions affecting you and your patients are made. □

practice management

Scheduling of office hours

LEIF C. BECK, LI.B.
VASILIOS J. KALOGREDIS, J.D.
BALA CYNWYD

'There is nothing inviolate about an office schedule. . . .Efficiency calls for a periodic look at the physician's activities with the question whether any scheduling changes would be helpful.'

Our surveys of some medical groups have been sought out of frustration at defects in the conduct of office practice. The symptoms seem to include one or more of the following: (a) an inability to finish office hours even reasonably within the scheduled time; (b) a constant overcrowding of the waiting room, with patient gripes as to long delays; (c) disruptions caused by numerous emergency appointments and/or "walk-ins;" and (d) a continuing feeling that office hours are so hectic as to be unpleasant for doctor, staff, and perhaps patient alike. We believe that these problems are more often than not curable if some conscientious attention and planning were applied.

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd. The above photo was taken at the Society's Practice Management Seminar held in May. Mr. Beck (center) headed the faculty, which included Roger Harrison, C.P.B.C., (left) owner of Roger Harrison Associates, Inc., Norman, Oklahoma, and Thomas E. Zirkle, C.P.B.C., (right) owner of Professional Management Associates, Inc., Chicago, Illinois.

In this respect, we are particularly struck by the occasional doctor with what we call a "God complex." This is the conscientious physician who is constantly running several hours late, whose patients adore him because of his devotion and care despite the tremendous burdens he shows, and who complains to us about the overwhelming demands upon his time and energy. While such a doctor is invariably conscientious and thorough, we find too often that he is also very poorly organized. It is as though he prefers to take a martyrlike pride in his burdens rather than change his system for greater efficiency.

We simply submit that almost any practice having the described problems can indeed improve its office situation. In some cases, we cannot recommend the specific changes without extensive time in the office, but we can describe certain principles which the practice should use for its own self-help. Some of those principles are discussed in this article in hopes they will help overburdened practices.

The doctor himself

The primary problem of many offices running con-

stantly behind schedule is the doctor himself. We too often receive aides' complaints that the doctor rarely arrives in time to start office hours as scheduled. A busy office starting its schedule 30 to 60 minutes late may, of course, stay that far behind (or more) throughout the day. The result frustrates the aides and is unfair to the patients.

There are many legitimate reasons for a doctor's delay in beginning office hours. For surgeons, complications or delays occur in the operating rooms. Hospital rounds for any doctor may be longer on some occasions than planned. *But all too often the delays are for less than these legitimate reasons.*

In many cases, the fact of occasional justified delays leads to a *habit* of delays, whether justified or not. Thus a doctor whose office schedule begins at 10 a.m. may, for instance, begin to accept the norm of arriving at 10:30—even if he simply stops for a cup of coffee in the hospital lounge or visits longer than usual with other doctors or patients. Except for really legitimate reasons, the physician's failure to start office hours on time is a symptom of bad medical practice.

Doctors should take their office obligations seriously enough that not all hospital duties must be over-riding. For instance, if surgery or rounds are extending longer than anticipated, some patient rounds might be deferred to later in the day (where medically insignificant). Similarly, new hospital consults often can be handled as well after midday office hours as ten minutes before the first office visit is scheduled. In short, the office schedule must be respected except where there is a *true* hospital priority.

Scheduling to the doctor

If the doctor routinely enters the office after hours begin, then serious consideration should be given to beginning his office schedule that much later. Some doctors' hospital practices have grown to the point that more time is needed to finish rounds, and yet their schedules never have been adapted to that fact. In such cases, we submit the following principle: *An office schedule should be tailored to fit the practice, and not vice versa.*

There is nothing inviolate about an office schedule. If a doctor cannot usually start until, say, 10:30, the printed sheet should not commit him to an earlier time. Efficiency calls for a periodic look at the physician's activities with the question whether any scheduling changes would be helpful.

First appointment

Many offices are of necessity behind schedule from the very first visit, with the result being a pressure to "catch up" from that time on. If, for example, the first patient is scheduled at 10 a.m., he or she will probably not actually be seen until 10:15 or later. A patient's arriving just 10 minutes late would contribute to this problem, as would the need for perhaps another 10 minutes in preparing a patient (undressing, taking blood, weight, etc.) before seeing the doctor.

We recommend, therefore, that practices start their office schedules ten or fifteen minutes e*arlier* than the doctor really plans to see his first patient. In the above example, scheduling one or two patients at 9:45 would probably permit a doctor arriving promptly at 10:00 (or earlier to do some paper work) to start his hours with no delay. This is simply an application of our rule—"fit the schedule to the facts, and not vice versa."

Wave scheduling

All office visits are not alike, nor are all patients equally prompt. Nevertheless, most schedules are printed up in inflexible, equal time slots as though there were no variations. "Wave scheduling" is an attempt to streamline office schedules to conform to these differences.

There are many applications of the wave theory. Under the basic theory, a practice scheduling patients every 10 minutes might instead schedule three patients every half hour and none in between. If one of those patients is 15 minutes late, the other two would nevertheless have kept the schedule intact; if one visit requires longer than normal time, the other two might be quick visits to average out the time usage. The assumption, of course, is that the 10 minute patient average will usually work out over several patients and that no patient will thus encounter more than a 20 minute delay.

Very few offices strictly apply a complete wave system. We find, however, that *modified* wave scheduling can be extremely helpful in parts of many doctors' appointment books. For example, a primary care practice seeing one patient each 10 minutes might schedule two patients at 10:00, no one at 10:10, one patient at 10:20, and then repeat this cycle through the day. Or an OB-GYN practice might group prenatal checkups into certain time slots for "wave" efficiency.

Grouping procedures for efficiency

Another approach to greater time saving is to analyze critically how a practice can group various types of office visits together for more efficiency. The answer to this problem will vary from doctor to doctor, and we are in no position to say how any individual should decide. What does strike us, however, is that so few doctors even ask themselves whether they can streamline their work this way.

Some OB-GYN men find that they can more rapidly *and more effectively* handle all their routine OB checkups if they are grouped in successive time slots. This would follow the well recognized principle that greater mental efficiency may arise when similar tasks are grouped together, so the mind need not jump across differing problems. If such is the case for a particular practice, then it should be made known to the receptionist. She might, for instance, be instructed to schedule all such checkups between 10:00 and 12:00 on certain days.

Other doctors find greater efficiency by a specific mix of long and short visits, or of new and old patients. Internists may prefer complete physicals to be scheduled at certain parts of each day. Whatever the preference, we urge each doctor to question it for himself and then to instruct his receptionist as to the desired scheduling format.

We also suggest in many cases that a doctor deliberately experiment with different grouping approaches to assure he is following the most efficient routine for himself. Deliberate attention to the possibilities may open up new ideas for his, his office's, and his patients' benefit.

Scheduling open times

One of the prime reasons an office fails to close on time is the onslaught of late-scheduled patients—both emergencies and "walk-ins." These patients all too often are tacked onto the end of an already crowded schedule, thus almost assuring a longer day. When such situations are routine, we feel the scheduling system should recognize the facts and leave *open times* for emergencies and walk-ins.

Probably the best time to leave open for these patients is the next to last hour before closing. If, for example, patients are scheduled until 5:00, we would suggest leaving the hour from 3:00 to 4:00 open until the morning of that day. Even if more than the usual hour's patients are squeezed into that hour, there may be some chance to catch up with just a normal load during the last hour. The principle here would be to schedule the emergencies and walk-ins so there will be some chance to catch up before the end of the day.

We have also seen referral practices facing an extremely serious problem. Their regular office schedules are filled so far into the future that newly referred patients cannot be seen for weeks. These new patients, and their referring physicians, may be the life blood of a practice, and the delays may cause the loss of potential future income. The situation is particularly apt for surgical practices in which the potential patient may seek another doctor for his surgery rather than wait.

We have suggested to such surgical practices that they set aside certain "new patient hours" in their appointment books. These would be time slots of perhaps one hour or more which may be filled in *only* with new patients until a very few days before the day in question. The receptionist might, for example, be instructed that the new patient hours cannot be used for any other purposes until the last two days; and during those last two days she should call other patients who may be willing to fill up those previously reserved time slots. New patients could thus be accommodated within only a few days, while there should be no lost time if new patients have not been scheduled.

Training the receptionist

It should be obvious that the usefulness of so many of these special scheduling devices depends upon the receptionist. This, in turn, depends upon the doctor's diligence in recruiting, training, and regularly supervising that person. As with so much of practice, success depends on personnel—but personnel proficiency in turn depends upon the doctor's attention to it.

The doctor simply must take the time to teach his receptionist how his hours should be structured. If the schedule is disrupted, he should constructively discuss how corrections can be made. And he should encourage the receptionist's own input since she may best see the problems and the possibilities.

Likewise, the doctor must train his aide to recognize what is truly an "emergency" requiring a prompt visit and what can be deferred for a routine later visit. She must take no chances in uncertain situations, but she also must learn to be extremely critical of patient requests. A doctor's receptionist can hardly handle this responsibility well without careful guidance from the physician.

Color coding of appointment book

One invaluable aid for receptionists is the use of color shadings on various time slots to guide scheduling priorities. This is useful since the press of phone calls and patients may easily cause a busy receptionist to forget the scheduling rules without a visual aid. Furthermore, since others in the office may substitute at the receptionist's desk in case of illness, lunch breaks, and the like, the visual aid may be of tremendous help to this lesser trained person.

One doctor's appointment book might, for example, have the hours from 10:00 to 12:00 shaded light red to indicate they are only for OB checkups. The hour from 1:00 to 2:00 might be shaded in light blue to indicate reservation for new patients. And so on. Regardless of the scheduling format, the color coding can make its actual application by the receptionist much more likely.

Office staff meetings

We believe that our various scheduling ideas can best be applied to an office if all aides are involved in the development. After all, they see the practice from day to day with maximum feel for its demands.

Therefore, we urge practices to hold regular office staff meetings at which scheduling difficulties can be discussed by all concerned. The input from aides, including periodic reviews to evaluate possible changes, should help make the schedule book responsive to the practice—and not vice versa.

Summary

No one or two of the ideas suggested in this article are certain of solving any particular office's patient flow problems. There are, however, many possible ways to improve the situation, and they simply require the physician's open minded attention. His efforts should be directed at tailoring the schedule to fit the practice, and not vice versa. □

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The "405" evaluation

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'Section 405 is an example of the chaos resultant from an intervention of legislation into medical practice. Without Section 405, the situation would be much simpler. I have no qualms whatsoever about involuntarily detaining a person whom I know to be mentally ill. . . . All Section 405 essentially does is place me in a position of liability for the destructive behavior of a person whom I do not *know to be mentally ill. This is, if anything, a gross abuse of the individual's civil liberties, as well as an intolerable burden upon the physician.'*

In spite of our familiarity with the time worn clichés about what can happen to man's best intentions, it is nevertheless most disappointing to observe malevolent consequences resulting from a beneficently intended procedure. The disappointment turns into frustration and then into frank intolerance, however, when proponents of the procedure obstinately refuse to recognize its malevolence, and persist in asserting its beneficence. It is as though physicians were to stubbornly continue prescribing blood letting for every internal disease, in spite of its futility at best, and injury at worst.

Prior to enactment of the Mental Health Act of 1966, a person considered to be in need of emergency psychiatric treatment, but who was refusing such care, could have been hospitalized involuntarily for a period of up to 21 days upon the application of a family member or person standing in *loco parentis* and after examination by a physician indicating the person was in need of hospitalization. Inasmuch as this procedure appeared open to abuse, in that a person could be confined and deprived of his freedom without due process of law, the Mental Health Act of 1966 discontinued this,

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and substituted instead a procedure under Section 405, that is essentially as follows:

> Emergency involuntary hospitalization can be implemented only if a person's behavior constitutes a clear and present danger to himself or others. If the latter exists, the person observing the dangerous behavior must call the County Mental Health Administrator or his delegate, and the latter may then authorize that the person be taken involuntarily to a physician for examination. If the physician finds a person to be mentally ill and in need of *emergency* hospitalization (i.e., dangerous to himself or others) he may then have the person confined in a hospital for a period not to exceed ten days. Involuntary hospitalization beyond that time can be only by means of a court order, following a hearing wherein the patient has an opportunity to be heard and represented in court.

It would appear that the intended protection against abuse of a person's civil liberties was by (1) introduction of a third party (the mental health administrator or delegate) other than the applicant and the physician, (2) the restriction of emergency detention to clear-cut cases of imminent danger to self or others, and (3) the reduction of the period of emergency hospitalization from 21 to 10 days. We may now examine these provisions, particularly as they are applied in practice.

The call for authorization of emergency hospital confinement is generally taken by the administrator's delegate. Who are these delegates, and what is their training qualifying them for this role? There are no required qualifications nor specialized training. Some delegates may have courses in psychology, social work, etc., but they need not necessarily even have a high school equivalency certificate. What do they know about the case in question that enables them to make a judgment about emergency hospitalization? Nothing other than what the applicant tells them on the phone. What if the applicant is advised by someone that in order to obtain "405" authorization, he must throw in a word or two about a suicidal threat? Many people do precisely that, even on instruction of the physician, if the latter feels that the patient is sick and there is no other way to get him into a hospital. But what if the applicant, for example the wife, wishes to "railroad" her husband, and simply prevaricates and tells the administrator's delegate that the husband has a history of previous mental illness, and is now brandishing a weapon, threatening to kill himself or her? The delegate then authorizes the patient to be taken involuntarily for examination.

But how are a person's civil liberties protected if he can be taken involuntarily to an emergency room simply because someone lied about him? The answer that defendents of Section 405 generally give is that the delegate's authorization is not for involuntary hospitalization, but only for involuntary examination. They say that the safeguard against unjust hospitalization is the physician's examination. This answer betrays either gross naivete or ignorance, or crass deception. Picture first a person being taken involuntarily into police custody, and conducted to a "psycho" emergency room. I would expect most normal people not only to be exceedingly irate, but also to put up considerable resistance. I challenge the finest of psychiatrists to distinguish, under these circumstances, between the rage of mental illness, and the wrath of justified indignation.

Let us assume, however, that the person brought to the emergency room has somehow managed to keep his composure, and that the physician's interview reveals no evidence of mental illness. Certainly, then the patient will be released, and his freedom will be assured. Not so!

Assume the following case, which is *not* an infrequent occurrence. A woman calls the Mental Health Administrator's delegate, and screams for help because her husband has gone insane and is threatening to kill her. He has taken it into his head that she has been running around with other men, and if he is not immediately hospitalized, he is apt to kill her. The delegate then authorizes police to take the man to an emergency facility for examination. Let us assume that when the police arrive, the husband, considering himself perfectly sane, goes along to the hospital willingly. At the emergency room, the physician examines the patient, and finds him to be correctly oriented, alert, and coherent. The man tells the physician that he has reason to suspect his wife of infidelity, (hardly an unheard of occurrence) admits discussing this with his wife, but denies making any threats. What does the physician do at this time?

If I am the physician, and I know that somewhere, someone has recorded the complaint of the applicant, what I do is quickly conjure up the following scene in my imagination. I see myself in the courtroom on the witness stand, on trial for charges of negligence in the case of a man who murdered his wife within three hours after I released him following my examination in the emergency room. I envision the twelve jurors, their gaze alternating between me and the four motherless orphans, age four through ten, who are sitting before them. I can hear the following dialogue:

Attorney: Now, Doctor, did you examine Mr. J. on the night of the twenty-third?

Doctor: Yes.

Attorney: Can you tell the court what that examination consisted of, and how long it took?

Doctor: I interviewed Mr. J. in the emergency room for about twenty minutes.

Attorney: And what did you find?

Doctor: I found him to be alert, correctly oriented, and perfectly coherent.

Attorney: Did he indicate to you that he thought his wife was having extramarital interests?

Doctor: Yes, he mentioned that he had reason to be suspicious of her.

Attorney: Are suspicions of this kind not found in paranoics?

Doctor: Yes, they can be, but they may also occur with due reason in normal people.

Attorney: Now Doctor, did you administer a Rorschach test to Mr. J. to detect possible presence of mental illness?

Doctor: No, that is hardly an emergency room procedure.

Attorney: Doctor, does it not happen quite often that a paranoic can get himself together and conceal his mental illness for a brief period of time, such as for this interview?

Doctor: Yes.

Attorney: Yet, you somehow concluded that this man was not mentally ill on the basis of a twenty-minute interview, without administering psychological tests. Is that true?

Doctor: Yes, but you see . . . .

Attorney: Answer the question, Doctor. Is that not true?

Doctor: Yes.

Attorney: Were you aware that Mr. J. had threatened to kill his wife that very day?

Doctor: I called Mrs. J. at her home but there was no answer.

Attorney: Were you aware that Mr. J. had suffered a psychosis and had been hospitalized eight years earlier?

Doctor: No, not at the time.

Attorney: Doctor, had you detained Mr. J. for several days as you had the authority to do under the laws of the Commonwealth, and had the opportunity to obtain information about his prior mental illness, and had the opportunity to administer the appropriate psychological tests, would you have made the diagnosis of paranoid psychosis?

Doctor: Quite possibly.

At this point in my fantasy, I see the eyes of the jurors well up with tears as they stare at the young orphans, then shift toward me as they frown, wondering whether I drive a Cadillac or Lincoln Continental, and then conclude that I was probably anxious to get out of the emergency room because I was tired after an afternoon of golfing. I terminate my reverie by realizing that if I do detain Mr. J. involuntarily, the risk is negligible. I have only to state that I acted in good faith, that I had a feeling that he might be mentally ill, and wanted further data and examination. If Mr. J. were to sue me for false imprisonment, I am relatively safe. At any rate, if I err in that direction there won't be four orphans in front of the jurists.

The point is simple. Examination under Section 405 occurs because someone, somehwere, has made a determination that a danger to life exists. Under these circumstances, and in our current climate of year round open season on physicians, *virtually every single 405 will lead to involuntary hospitalization*. The latter is true even when the examining physician is a competent psychiatrist. In most cases, however, the physician in the emergency room is *not* a psychiatrist, because the law provides that any licensed physician can make this determination. The nonpsychiatric physician feels even more vulnerable in releasing an allegedly dangerous person.

It should be further noted that the "not to exceed ten days" is a myth. If court action is instituted within the ten day period, the person may be detained in the hospital involuntarily for as long as *four weeks* without having had representation in court by an advocate who has personally interviewed him.

The basic fallacy of Section 405 is that it establishes "danger" as an item with which the physician must deal. Mental illness of even the greatest malignancy does not suffice; only "danger." Essentially, the physician must, in a brief interview, not only assess the presence or absence of mental illness, but also place himself in a position to judge the degree of "danger." The latter is a nonmedical concept, and the physician's accuracy of predicting danger is no greater than that of any other person.

The assumption of a "clear and present danger" prior to the physician's examination leaves the physician with no reasonable alternative other than to detain for observation. This assumption of danger is based on a telephone conversation between an applicant and a person with questionable qualifications for making this judgment and who has no access to factual data. How anyone can by the farthest stretch of the imagination construe this as a protection of civil liberties is beyond my comprehension.

Section 405 is an example of the chaos resultant from an intervention of legislation into medical practice. Without Section 405, the situation would be much simpler. I have no qualms whatsoever about involuntarily detaining a person whom I know to be mentally ill. I am willing to take my chances of being charged with false imprisonment, in those instances when I can document the behavior and symptoms of the patient, and the findings of psychiatric and psychologic examinations that led to the decision for involuntary detention. I do not need Section 405 to appropriately treat a person whom I know to require treatment. All Section 405 essentially does is place me in a position of liability for the destructive behavior of a person whom I do *not* know to be mentally ill. This is, if anything, a gross abuse of the individual's civil liberties, as well as an intolerable burden upon the physician.

The immunity to liability contained in the Mental Health Act of 1966 is of as much value as a sieve to fetch water. Can anyone convince the jury that I was not negligent and acted "in good faith," in Mr. J.'s case?

Attempts to compose a better statute for emergency detention will be of no greater success. If there is genuine concern with safeguarding people's civil liberties, the only solution is to remove any legal authorization for involuntary detention. The consequences of the latter will be that the physician will detain persons involuntarily only when he has no real fears of liability, i.e., if and only if he has demonstrable indications that involuntary hospitalization was essential. In the final analysis, isn't this really all that is necessary? □

Kidney donation-pressing need in end stage renal failure

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'During the next 5-6 years it is estimated 10-12,000 new patients will require treatment each year and 50-60,000 patients will constitute a steady population needing treatment for end stage renal failure. The National Kidney Foundation estimates that, if sufficient kidneys were available, 6,000 people yearly could benefit from kidney transplantation.'

Each year in the United States 60,000 people die of uremia.[1] Many of these patients can be helped by the use of chronic hemodialysis and many can be cured by renal transplantation. Since the federal government now has undertaken fiscal responsibility for most of the care of chronic renal disease, hemodialysis is increasingly available for all who need it. There is, however, a critical factor presently limiting treatment for end stage renal failure—lack of sufficient kidneys for transplantation.

Currently, there are nearly 14,000 patients on chronic dialysis in the United States, and 2,500 renal transplants are done each year.[3] During the next 5-6 years it is estimated 10-12,000 new patients will require treatment each year and 50-60,000 patients will constitute a steady population needing treatment for end stage renal failure.[1] Some 3,500 patients may become transplant recipients each year—over half of whom will have successful transplants and leave the system. The National Kidney Foundation estimates that if sufficient kidneys were available, 6,000 people yearly could benefit from kidney transplantation.[2]

For most patients with chronic renal failure the best rehabilitation is provided by a well functioning transplant. The best chance for a well functioning transplant is provided by a kidney donated by a close family member (Table I). However, since most patients do not have a healthy family volunteer, increasing reliance must be placed on donation of healthy organs from unrelated persons dying of other causes.

Dr. Colberg is associate professor of surgery and chief of the transplantation service, and Dr. Lasker is professor of medicine and director of the dialysis unit at Jefferson Medical College and Jefferson University Hospital of Thomas Jefferson University.

Currently in the United States less than two-thirds of transplanted kidneys come from cadavers. In 1972 only 52.3 percent of the transplants in this country were from cadaver donors; this was in striking contrast to Europe (78.8 percent) and to Australia (98.3 percent).[4]

Much more can be done in this country to make use of this valuable source of healthy kidneys. Since the number of family donors is limited and is virtually fully utilized now, any large scale increase in transplantation can only come about by a large scale increase in the availabil-

TABLE I

Transplant Function and Patient Survival in Renal Transplantation According to Kidney Source—ACS-NIH Renal Transplant Registry Data[4]

	TRANSPLANT FUNCTION		
	1 YR	3 YR	5 YR
Related - sibling	74%	73%	59%
- parent	76%	63%	51%
Unrelated cadaver	45%	42%	29%
	PATIENT SURVIVAL		
	1 YR	3 YR	5 YR
Related - sibling	87%	82%	71%
- parent	92%	79%	66%
Unrelated cadaver	72%	61%	43%

TABLE II

World Organ Transplants—January 1, 1975—ACS-NIH Organ Transplant Registry[5]

	Kidney	*Heart*	*Liver*	*Pancreas*	*Lung*
Recipients	17,936	257	220	36	36
Alive with functioning grafts	8,000	44	20	1	0
Longest survival with functioning graft (yrs.)	18	6.2	5.5	2.7	0.9

ity of healthy kidneys from cadavers.

The increasing awareness of the general public of the need for donation of kidneys and other organs still falls far short of providing for the urgent need both for kidneys and for corneas. The need for other organs is less urgent since heart and liver transplants are performed in limited programs at certain centers. Pancreas and lung transplants remain experimental.

Kidney transplantation is by far the most widely practiced and most successful form of clinical transplantation in the world. (Table II) Since the first renal transplant 20 years ago, there are currently over 8,000 patients alive with functioning grafts.

The opportunity to donate after death one's own organs or those of a close relative is an opportunity to provide a meaningful gift of life to two patients at a time of family tragedy. It is a chance to give some meaning to what otherwise seems a senseless loss and can often allay some of the family's grief. This gift is made easier by the Uniform Anatomical Gift Act,[7] which provides a simple and legally clear means of donation for transplantation or medical research.

In this article, we wish to set forth the criteria for identification of the potential donor, maintenance of renal function, and the practical steps in providing viable kidneys for transplantation.

TABLE III

Steps in Kidney Recovery for Transplantation

1. Identifying the Potential Donor
2. Medical Evaluation
3. Maintenance of Renal Function
4. Obtaining Family Permission
5. Notification of Kidney Recovery and Transplantation Team
6. Diagnosis of Brain Death
7. Removal of Kidneys and Preservation
8. Matching with Suitable Recipient
9. Transplantation

Cadaver donation and current success of renal transplantation

For any patient the best matched donor (besides a monozygotic twin) is a sibling who is ABO compatible and is identical for the 4 HL-A transplantation antigens. Over 90 percent of these recipients have a well functioning transplant at the end of one year with only slight functional loss past that time. With the average family donor (a sibling, parent, or child) 75 percent of the grafts are functioning well at one year. Patient survival in both instances of course is higher. Unfortunately, there are not enough suitable family donors for the victims of chronic renal failure. Therefore, unrelated donors whose kidneys are willed or given upon their death must provide kidneys for most of the renal transplants currently done in the United States.

The current average level of success for cadaver renal transplantation is 45 percent graft function at one year with some further loss beyond that time. Many centers have improved upon this level of success: Australia, where 98 percent of all transplants are from cadavers, reported a 5 year graft function of 42 percent versus the 29 percent average reported in the Registry.[4]

Most transplants are lost by immunologic rejection. Current methods of matching are only partially successful in avoiding incompatible donor-recipient pairings. Retransplantation is feasible in most patients who reject; there is only slightly less success than with a primary graft. This, however, is very much dependent upon cadaver organ supply, since the matching criteria necessarily are stricter for second or multiple transplants.

Even with current methods of matching and immunosuppression, this record can be improved by greater availability of cadaver kidneys, since this availability would allow better donor-recipient matching and better selection of quality kidneys. More kidneys would permit greater flexibility in the treatment of patients in whom graft function is impaired. More kidneys would also decrease the waiting time on dialysis for patients. The longer the wait on dialysis, the higher the risk that the patient will be sensitized to tissue antigens and will be a difficult match for a transplant.

Though there is much room for improvement in clinical transplantation, the current level of success is a remarkable achievement in providing rehabilitation and cure for many patients with chronic renal failure and allowing them to lead normal lives. A decade ago end stage renal failure was usually 100 percent fatal.[6] Even today, mortality on dialysis remains approximately 9 percent per year,[1] and, for the non-transplanted dialysis patient, a 3 year fatality rate of 32.5 percent is experienced, with the highest risk in the first year of dialysis.[3]

Uniform Anatomical Gift Act

The Uniform Anatomical Gift Act, which became law in the Common-

UNIFORM DONOR CARD

OF _____
Print or Type name of donor

In the hope that I may help others, I hereby make this anatomical gift, if medically acceptable, to take effect upon my death. The words and marks below indicate my desires.

I give: (a) _____ any needed organs or parts
(b) _____ only the following organs or parts

_____
Specify the organ(s) or part(s)

for the purposes of transplantation, therapy, medical research or education;
(c) _____ my body for anatomical study if needed.

Limitations or special wishes if any: _____

Signed by the donor and the following two witnesses in the presence of each other.

_____ _____
Signature of Donor Date of Birth of Donor

_____ _____
Date Signed City & State

_____ _____
Witness Witness

This is a legal document under the Uniform Anatomical Gift Act or similar laws.

wealth of Pennsylvania January 1, 1970, has been passed in 49 other states and the District of Columbia. Donations of kidneys or other vital organs may now be made simply by a witnessed statement to that effect by any competent person prior to death. The Donor Card (Figure 1) is a legal will which should be carried by the donor. It takes legal precedence over the wishes of the next of kin, although in practice one does not act contrary to the wishes of the next of kin. The donation takes effect immediately upon death of the donor.

Such donation may also be made by the next of kin just prior to death of the patient. It may be made in the following order of priority: (1) spouse; (2) adult son or daughter; (3) either parent; (4) adult brother or sister; (5) guardian; or (6) any other person authorized or under obligation to dispose of the body.[7]

This gift may be made by any next of kin: (1) when persons in prior classes are not available at the time of death; (2) in the absence of actual notice of contrary indications by the decedent; and (3) in the absence of actual notice of opposition by member of the same or prior class of next of kin. The Act also provides that "a person who acts in good faith in accord with the terms of this act . . . is not liable for damages in any civil action or subject to prosecution in any criminal proceedings for his act."[7]

Suitability of potential donors

It is obvious that not every dying person would be a suitable donor of kidneys for transplantation. Fundamentally, patients with normally functioning kidneys who have suffered irreversible catastrophic brain injury are potential kidney donors after death. These patients include those with: (1) brain trauma; (2) intracranial hemorrhage; (3) primary brain tumors which do not spread beyond the central nervous system; (4) anoxic brain damage from any cause; or (5) homicides and suicides (with the medical examiner's or coroner's permission).

The prime age for donation is between the ages of 5 and 50. Some patients will be acceptable donors below the age of 5 and up to the age of 65, provided renal function is excellent. However, outside the 5-50 year age limits there is a diminution of renal reserve and the kidneys do less well.[4]

The following conditions are contraindications to donation: (1) acute or chronic renal disease; (2) severe or malignant hypertension; (3) sepsis or untreated infection (treated infections may be acceptable); (4) malignant neoplasms except for nonmetastatic brain tumors (since cancer can be transmitted to grow and metastasize in the immunosuppressed host); (5) diabetes (usually); and (6) shock and oliguria (if unrelieved).

Certain trauma cases including operative deaths, homicides, and suicides require the approval of the medical examiner or the coroner in most localities. In general, medical examiners and coroners are most helpful in allowing donation to take place. The usual requirements are prior notification and careful recording of findings at donor nephrectomy.

Laboratory studies of potential donors should demonstrate a normal creatinine or blood urea nitrogen and the terminal creatinine should be no higher than twice normal. Urine culture should be sterile and other laboratory studies should be consistent with the absence of sepsis, renal disease, and malignancy. Finally, the warm ischemia time—the time between cessation of circulation and the removal and cold perfusion of the kidneys—should be less than 30 minutes.

TABLE IV

Criteria for Cadaveric Kidney Donation

Ideal donors are previously healthy individuals who have suffered an irreversible catastrophic brain injury.

1. Age 5-50 ideal; 1½-65 possible
2. No renal disease; acute or chronic
3. Serum creatinine normal (less than 2 x normal terminally)
4. No sepsis; no untreated infection
5. No malignant neoplasm other than primary (non-metastasizing) brain tumor
6. Warm ischemia time (circulation to cold storage) less than 30 minutes
7. Brain death usually; rarely cardiac arrest (must resuscitate)

Obtaining consent

In the usual case the donor has not signed a card prior to his terminal illness, and consent must be obtained from the next of kin. The relatives should be approached gently and should be informed by the attending physician that the patient is unlikely to recover. They should also be informed that maximal care will be given the patient and that the attending physician has no direct role in organ recovery or in transplantation thereafter. It should be stressed that donation of the patient's organs after death is an opportunity to give a gift of life to other patients. Under the Uniform Anatomical Gift Act, written consent and witnessed telephonic consent by the next of kin for removal of kidneys after death for transplantation are both valid. Autopsy permission is desirable to rule out transmissible disease in the donor, as well as to advance medical knowledge.

Maintenance of renal function in potential cadaver donors

Supportive measures should be maintained in potential donors until the feasibility of organ donation is determined. If, in the opinion of the responsible physician, there is no contraindication to renal supportive measures, the following should be undertaken: respirator, which is necessary eventually in all potential donors, and resuscitation from cardiac arrest. If the cardiac arrest lasts longer than 10 minutes or effective circulation cannot be restored, the patient is no longer a candidate because of excessive renal damage. The maximum time allowable without circulation to the kidneys is 30 minutes. Also necessary is moni-

toring the following: intake and output, vital signs, central venous pressure, urinalysis, urine culture and sensitivity, creatinine or blood urea nitrogen and serum electrolytes.

Blood pressure maintenance is essential and may be difficult. Deterioration of brain stem function will progress to loss of regulation of respiration, temperature, and blood pressure. Diabetes insipidus often occurs in brain damaged patients and will give a false sense of security because of the large urine output. However, the patient may become quite dehydrated with later precipitous drop in blood pressure unless adequate replacement is carried out. Pitressin may be needed for control. Large volumes of colloid (albumin or plasma solution) and crystalloid (Ringer's lactate or saline) may be necessary to maintain blood pressure and a CVP of 10-15. Only if the blood pressure does not respond to adequate volume replacement should vasopressors be used, since these agents cause renal ischemic damage. The preferable agent is isoproteranol (Isuprel) which must be titrated against cardiac arrhythmias. Metaraminol (Aramine) is used only if necessary and levarterenol (Levophed) should be avoided if possible.

Notification of a transplant center

When a potential donor has been identified, a transplant center should be called at the earliest opportunity for guidance on management. Only by early notification can smooth coordination be achieved. It is far better for transplant centers to learn about patients in whom the medical criteria are not fulfilled or for whom permission is not obtained than to lose the kidneys from a single potential donor. In Pennsylvania currently there are seven renal transplant programs.

In Western Pennsylvania Presbyterian-University Hospital at Pittsburgh has the sole program. Notification of a potential donor in the region should be made to the Transplant Registry at (412) 682-8100, extension 445 (a 24 hour number).

TABLE V

Harvard Criteria for Brain Death[1]

Criteria valid when no CNS depressants (e.g. barbiturates) present, and no profound hypothermia (below 90° F or 32.2° C)

1. Deep Coma—no response to stimuli; no movements
2. Apnea—no respiratory effort in presence of normal pCO_2
3. No reflexes—usually tendon and withdrawal spinal reflexes are absent. Pupils are fixed and dilated. No corneal, cold caloric, postural reflexes are present

A flat EEG is of great confirmatory value
The above criteria are met on two occasions 24 hours apart

In Eastern Pennsylvania there are 6 programs: Albert Einstein Medical Center (Northern Division), Hahnemann Hospital, Hospital of the University of Pennsylvania, Lankenau Hospital, St. Christopher's Hospital for Children, and Thomas Jefferson University Hospital. These centers have recently formed the Delaware Valley Transplant Program on a regional basis with a full time coordinator and with a rotational schedule of organ salvage teams and of organ distribution. The telephone number is (215) KIDNEY-1 ([215] 543-6391), a 24 hour "hot line."

Typing for the ABO groups and for the HL-A transplantation antigens is done on all donors for selection of suitable recipients. Tissue typing is done on lymphocytes from lymph nodes preserved in saline or from heparinized blood. Although it is very helpful to have tissue typing done ahead of time, most frequently this is done at the same time the kidneys are being preserved, using lymph nodes, spleen, or blood removed at the time of nephrectomy.

Advice will be provided over the telephone and in person by the transplant organ recovery team. The team will also supply drugs, solutions, and equipment for the removal and preservation of the kidneys, beyond the usual hospital supplies. The preferred method is to have the coordinator and the kidney recovery team proceed to the community hospital where organ removal would take place after medical evaluation and permission of next of kin have been obtained and death has been pronounced. Administrative approval should be obtained beforehand in hospitals where cadaver organ removal for transplantation has not been undertaken previously.

Pronouncement of death

The vast majority of cadaver donors in the United States are pronounced dead on the basis of irreversible cessation of brain function (brain death) rather than the cessation of respiration and cardiac activity (cardiac death). The reason for this is the necessity of removing the kidneys before they too are irreversibly damaged by ischemia. This requirement necessitates full cardiorespiratory resuscitation until the patient can be pronounced dead by the attending physician on brain criteria or until a second cardiac arrest occurs under circumstances which allow prompt removal and cooling of the kidneys (within 30 minutes).

The diagnosis of death on the basis of irreversible cessation of brain activity has gained impetus since the 1968 report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death. These criteria were established for the certainty of the point of irreversible brain death, without primary concern for organ transplantation.

The essential criteria are: (1) unreceptivity and unresponsiveness to stimuli, (2) no spontaneous movements or breathing, and (3) no reflexes, with the exception that residual spinal reflexes may be present in some cases.

The above criteria are valid when central nervous system depressants such as barbiturates are not present and when there is no profound hypothermia (below 90 degrees or 32.2 degrees centigrade).

A flat or isoelectric electroencephalogram is of great confirma-

tory value although not essential in the original opinion of the Harvard Committee and later opinions of neurologists. [8,10,11,12,13].

The above criteria are to be reapplied after a suitable interval and documented. The Harvard Committee recommended 24 hours although this has been shortened in some centers.[10] In the presence of grossly visible evidence of massive brain injury the waiting period can be reduced.[9,12]

There are additional safeguards which are applied in the diagnosis of brain death. Death is pronounced by the attending physician or his designee, not by a member of an organ salvage or transplantation team. The diagnosis is usually confirmed and recorded by a second licensed physician (a neurologist or neurosurgeon is often helpful). The waiting period of 12-24 hours is a further check against inaccurate diagnosis.

The legal definition of death is generally accepted as the cessation of life, *as defined by physicians* and as a question of fact to be decided in each case. The states of Kansas, Maryland, and Virginia have legislation specifically recognizing brain death as well as cardiac death.[10] However, such legislation may be more troublesome than helpful.[14] The law requires that death, which is a process beginning with death of higher brain centers which are most sensitive to anoxia and ending with total cellular death, be defined to take place at a precise time.[14] An excellent recent discussion of brain death is given by Harp.[10]

Brain death has been defined by an international committee of neurologists as "an irreversible cessation of function of all cerebral structures including the cerebellum and brain stem down to spinal segment C1. The state of brain death prevails in patients in which other organs are kept functioning by artificial ventilation and pharmacological means, as well as intravenous fluids and electrolyte administration, etc. The state of brain death never becomes chronic. The heart ceases to function as a rule within 1-5 days following the cessation of brain functions. . . . Spinal reflexes as well as blood pressure reactions to pain stimulation may, however, be present."[10]

General procedures

When the suitability of the potential donor has been determined, permission from the next of kin obtained, and the criteria of brain death met, then death can be pronounced and the body moved to the operating room for removal of the kidneys.

Where indicated, for example, any violent death, the permission of the medical examiner or coroner must be obtained. Autopsy permission is always highly desirable.

When death is pronounced, the pronouncement time and signatures are recorded in the chart. The clinical chart is closed with the death of the patient and no further notes are made in it. The removal of the kidneys is then performed in the operating room as a sterile limited autopsy procedure. In patients pronounced dead by brain criteria, blood pressure and heart beat are still present and continued cardiorespiratory support is necessary for the vitality of the kidneys.

All expenses directly related to the removal of kidneys for transplantation are reimbursed by the transplant hospital's kidney acquisition cost center. The fees and costs reimbursed are those directly relating to kidney salvage and not the care of the donor. They include professional fees, electroencephalography, operating room costs, medications, and special tests.

After death, methylprednisolone (solumedrol), heparin, and occasionally furosemide (Lasix) and mannitol are administered to the donor. The kidneys are then removed with great care and flushed by gravity flow of a cold electrolyte solution to cool the core of the kidney rapidly to 0-5 degrees centigrade and to flush out all blood.

There is evidence that kidneys can be maintained by cold storage in Ringer's lactate for up to 10 hours and for up to 24 hours in Collins or Sacks solution. However, the most common method is to place the kidneys on the perfusion machine which will allow preservation for 48 hours.[15] This time is valuable in order to perform tissue typing and careful crossmatching in the laboratory and to select and prepare the recipients.

With increasing experience with cadaver donation and with wider development of the special skills necessary in removal of the kidneys for transplantation, we would expect that the organ procurement procedure in Pennsylvania would become similar to that in New England where skilled community physicians and surgeons would manage organ procurement up to delivery to the transplant centers.

In general, the care of most brain trauma patients occurs in the community hospital, whereas most transplantation takes place in university hospital centers. Only by increasingly greater cooperation between community hospitals and transplantation centers can greater progress be made into the treatment and cure of chronic renal failure. □

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BACTERIAL ENDOCARDITIS WALLET CARD

Name _____

needs protection from

BACTERIAL ENDOCARDITIS

because of existing

HEART CONDITION

For Gastro-Intestinal and Genito-Urinary Tract Surgery and Instrumentation And also for any Surgery of Infected Tissues.

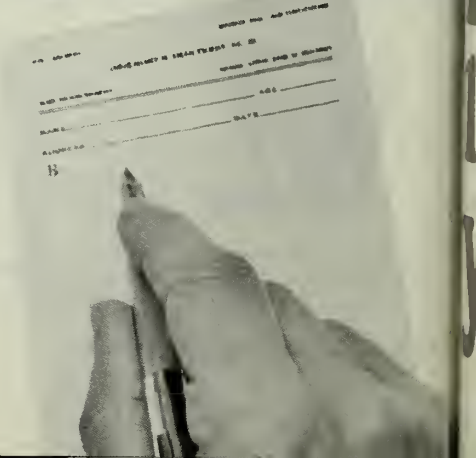
I. For most patients: **Penicillin**	600,000 units of procaine penicillin G mixed with 200,000 units of crystalline penicillin G intramuscularly one hour prior to procedure and once daily for the two days following the procedure.
PLUS **Streptomycin**	1 to 2 grams intramuscularly, one hour prior to procedure and once daily for the two days following the procedure. **For children:** 40 mg/kg intramuscularly one hour prior to the procedure and once daily for the two days following the procedure. (Not to exceed 1 gm/24 hours.)
OR **Ampicillin**	25 to 50 mg/kg given orally or intravenously one hour prior to procedure; and then 25 mg/kg every six hours for the remainder of that day and for the two days following the procedure.
PLUS **Streptomycin**	(As above.)
II. For patients suspected to be allergic to the penicillins, **Erythromycin** can be given (instead of penicillin or ampicillin)	(For dosage and duration for Erythromycin, see *suggested prophylaxis schedule for dental procedures, p. 2)*
PLUS **Streptomycin**	(As above.)
Vancomycin can be given as an alternative to Erythromycin	0.5 gm to 1.0 gm intravenously one hour prior to procedure and then 0.5 gm intravenously every six hours for the remainder of that day and for the two days* following the procedure.
PLUS **Streptomycin**	**For children:** 20 mg/kg one hour prior to procedure and then 10 mg/kg every six hours for the remainder of that day and for the two days following the procedure. (As above.)

For Dental Procedures and also for Tonsillectomy, Adenoidectomy and Bronchoscopy.

I. For most patients: **Penicillin**	**a) Intramuscular:** 600,000 units of procaine penicillin G mixed with 200,000 units of crystalline penicillin G one hour prior to procedure and once dally for two days* following the procedure. or **b) Oral:** 1. 500 mg of penicillin V or phenethicillin one hour prior to procedure and then 250 mg every six hours for the remainder of that day and for the two days* following the procedure. OR 2. 1,200,000 units of penicillin G one hour prior to procedure and then 600,000 units every six hours for the remainder of that day and for the two days* following the procedure.
II. For patients suspected to be allergic to penicillin or for those on continual oral penicillin for rheumatic fever prophylaxis, who may harbor penicillin-resistant viridans streptococci: **Erythromycin**	**Oral** **Adults:** 500 mg one and one-half to two hours prior to procedure and then 250 mg every six hours for the remainder of that day and for the two days* following the procedure. **Children:** The dose for small children is 20 mg/kg orally one and one-half to two hours prior to the procedure and then 10 mg/kg every six hours for the remainder of that day and for the two days* following the procedure. *NOTE:* Erythromycin preparations for parenteral use are also available. *Or longer in the case of delayed healing.

The wallet card shown above is available from the American Heart Association for your patients with rheumatic fever or congenital heart disease. It is intended as a reminder to these patients that they require protection from bacterial endocarditis when undergoing dental or surgical treatment and should discuss their condition with the dentist or surgeon. For a sample copy or to order quantities please contact your local Chapter or the American Heart Association, Pennsylvania Affiliate, P.O. Box 2435, Harrisburg, Pennsylvania 17105.

Bioequivalenc



the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.

"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and (b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or (c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

protecting the integrity of your prescription

trauma

Peritoneal lavage in diagnosis of intraperitoneal injury

GARY G. NICHOLAS, M. D.
WILLIAM W. DeMUTH, B. S.

Hershey

Peritoneal lavage is a worthwhile diagnostic procedure of proven usefulness in assessing patients with traumatic injuries in which intraabdominal injury is suspected. The most suitable candidates are multiply injured patients who are obtunded because of a head injury, and those with thoracic injuries in whom abdominal injuries are suspected. The high incidence of false negative abdominal paracenteses has made lavage a much preferred procedure.

One method which has been found to be safe and reliable is described.

Procedure

1. Empty the bladder, preferably by catheter.

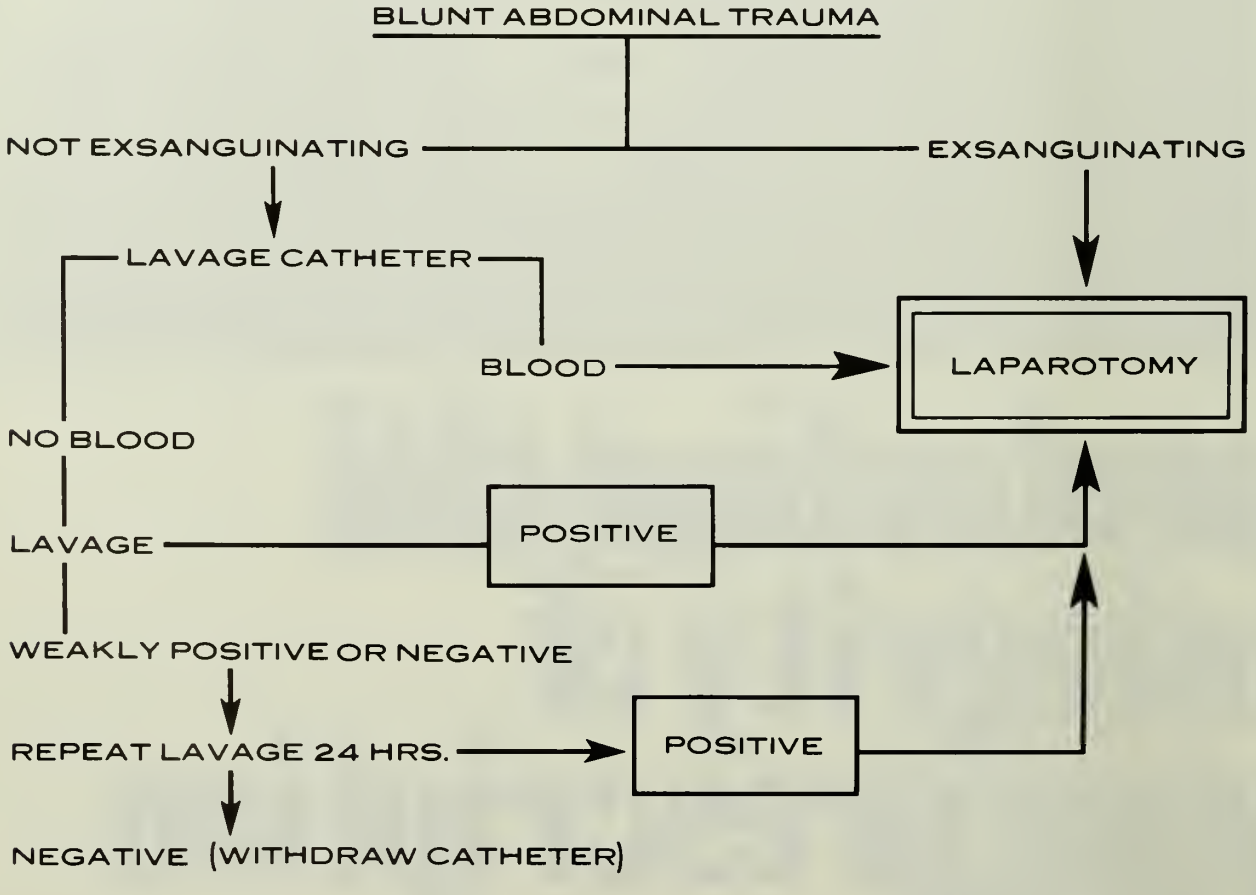
2. Infiltrate the skin 3 cm below the umbilicus in the midline with 1 percent xylocaine and make a 2-3 cm vertical incision down to the linea alba. Carefully ligate bleeding vessels to avoid a false positive lavage.

3. Incise the linea alba and grasp the edges with Allis forceps. When bleeding is controlled, open the peritoneum for a few millimeters and thrust a peritoneal dialysis catheter into the peritoneal cavity.

4. If blood or other diagnostic material is not encountered, close the skin about the catheter with sutures and attach a standard intravenous tube which is filled with saline prior to insertion. If blood, bile, or other intestinal contents are encountered, the tube should be withdrawn and preparations for laparotomy made.

5. If a diagnosis of visceral injury is not made upon passage of the tube, 1,000 cc of saline is run into the peritoneal cavity (proportionately less in children) and the bottle then placed on the floor and allowed to drain while it is vented to air.

The recovered fluid may be ex-



amined for red blood cells, leukocytes and bacteria as well as amylase. From a practical point of view, the inability to read newsprint through the intravenous tubing usually means that the amount of blood in the lavage fluid is sufficient to indicate that laparotomy is desirable. Testing has demonstrated that in a patient having a normal hematocrit, this level of turbidity is reached when 15-20 cc of blood per 1000 cc of aspirate is present, and the hematocrit will be in the vicinity of one. The entire procedure can be accomplished in fifteen to thirty minutes.

The following table indicates significant findings:

Lavage Fluid	*Significant Levels*
RBC	Grossly bloody or more than 100,000 RBC/cu mm with hematocrit 1
WBC	More than 500 cells/cu mm
Bacteria (Gram stain)	Pathologic when present
Amylase	Above 100 Somogyi units
Bile	Pathologic when present

Contraindications to peritoneal lavage

1. Gunshot and stab wounds
2. Previous multiple abdominal operations
3. Positive needle paracentesis
4. Any obvious indication for laparotomy

Peritoneal lavage DOES NOT: (1) identify all retroperitoneal injuries; (2) localize site of injury; or (3) identify site of bleeding *within* substance of spleen or liver.

Complications of peritoneal lavage have been few when the above method was employed. Perforations of bowel, vessels, and bladder have been reported with lavage but we think most will be avoided if care is used in introducing the dialysis catheter. Air is frequently introduced into the peritoneal cavity during the procedure; therefore, roentgenograms should be made prior to using this technique if free air is to be an indication for laparotomy.

Peritoneal lavage does not take the place of pyelography, arteriography, and scans in ruling out injury, especially those in the retroperitoneal space. Those who have used peritoneal lavage extensively have generally been enthusiastic about its utility in avoiding missed diagnoses and in facilitating earlier operation in a patient requiring it. By its use, significant intraperitoneal injuries will rarely go undetected.

This paper was prepared by the department of surgery of The Milton S. Hershey Medical Center, The Pennsylvania State University, Hershey. The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services assist in the dissemination of information on trauma.

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Abdominal aortic aneurysm in the community hospital

WILLIAM P. COGHLAN, M.D.
VINCENT D. CUDDY, M.D.
PAUL A. PUPI, M.D.

Beaver Falls

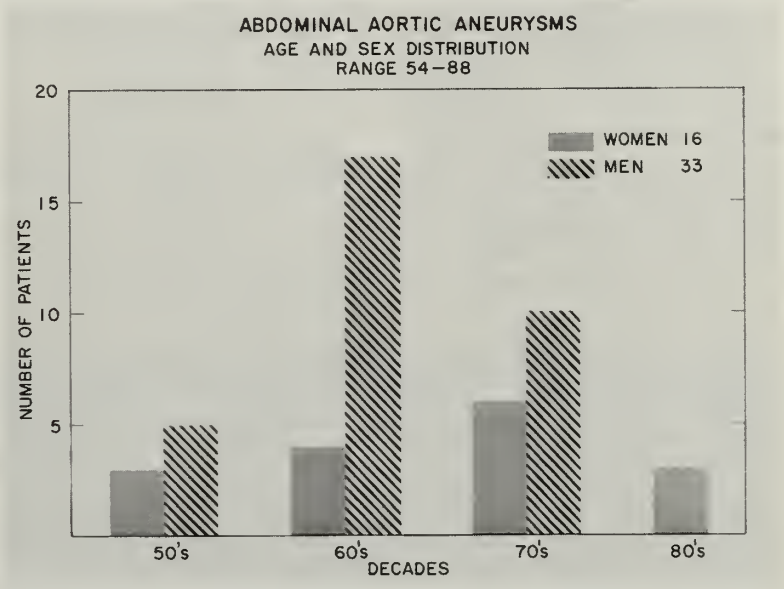
With very few notable exceptions, papers[1] describing surgical experience with abdominal aortic aneurysms emanate from large University Medical Centers. Therefore, we felt that it may be of interest to describe our experience with this entity as it evolved in a community hospital. Our hospital is the Medical Center of Beaver County, Incorporated, which is a recent merger of three small hospitals. They are physically separate facilities. This is a true community hospital with no house staff and only the major specialties represented. Beaver County is an industrial community, with a population of just over 200,000, located 30 miles northwest of Pittsburgh, just adjacent to the borders of Ohio and West Virginia.

We have operated upon 49 patients with abdominal aortic aneurysms, 36 of which were performed electively and 13 performed as emergency procedures for rupture of the aneurysm.

The age and sex distribution of our patients conform to that in the literature. This is a disease which occurs predominately in men over fifty years of age.

Etiology

The most attractive theory of etiology is that proposed by Benjamin in 1967. His theory was that occlusion of the nutrient vessels to the aortic wall caused degeneration in the tensile strength and lead to aneurysm formation. He showed that vasa vasora were fewer in number in the abdominal aorta and failed to cross the vascular wall from one side to the other. Since the vasa vasora are the first branches of the lumbar arteries, and these are frequently occluded in patients with aortic atherosclerosis, it is to be expected that blockage of the aortic blood supply causes necrosis and subsequent healing with inelastic scar.[2]



With the beginning of sacculation, the operation of the Laplace principle is brought into play, i.e., increased diameter results in increased wall tension, which explains the progressive nature of aneurysms.

The abdominal aorta is particularly subject to the hemodynamic stress from the presence of a standing shock wave, the effect of collision of the normal pulse wave colliding with a reflection of the preceding pulse wave from the bifurcation.[10]

Diagnosis

Out of all the patients, 14 were without symptoms. The most common symptom was pain which was present in 35 patients. Most commonly this was abdominal pain, but some complained of back pain alone or a combination of back and abdominal pain. There was occasional lower extremity pain. The pulsating abdominal mass was noted by 6 patients who called it to the attention of their physician; 14 patients had their aneurysms picked up on routine physical examination. Of the 49 patients, 47 had an expansile pulsating abdominal mass.

A plain x-ray film of the abdomen, an intravenous pyelogram and/or a barium enema showed a retroperitoneal soft tissue mass with a calcific rim in 32 of the 42 patients x-rayed.

Aortography was performed in 6

The authors are in the department of surgery at the Medical Center of Beaver County, Inc. Dr. Coghlan is chairman of the department.

patients. With the notable exception of Robicsek[16] and his group at the Charlotte Memorial Hospital, most authors agree that aortography is unnecessary. Most carry out aortography only if there is a concern about involvement of the renal arteries and/or about distal occlusive disease.

Other special techniques that can be used, but with which we have no experience, are ultrasonic tomography, radionuclide aortography and lateral tomography. The former two require relatively expensive equipment not readily available in a community hospital. Lateral tomography, as described by Ivengar, et.al,[12] is available and relatively inexpensive and would appear to give nearly the same information as the other two diagnostic modalities. It aids, in the diagnosis of aneurysm in the obese patient, in the differentiation between a tortuous atherosclerotic aorta and an aneurysm, and in periodic assessment of an aneurysm in a patient who is being followed because of the small size of the aneurysm and/or because there is some medical contraindication to resection.

Associated disease

As would be expected, the majority of our patients had associated vascular disease; 29 patients had arterial hypertension or a history of it and 7 patients had a previous myocardial infarction. Out of the 49 patients, 36 had abnormal electrocardiograms. During the course of their hospitalization, 12 patients required digitalis. Other manifestations of vascular disease in our patients were aneurysm and/or occlusive disease of the iliac arteries; angina and previous cerebrovascular accidents. Only 4 patients were diabetic, 5 patients had cholelithiasis and interestingly, 3 patients had a Meckel's diverticulum. There were 5 malignant neoplasms present either at the time or developed later, 2 colon carcinomas, 1 adenocarcinoma of the rectum, 1 carcinoma of the bladder, and 1 bronchogenic carcinoma.

Management

The decision regarding the management of ruptured abdominal aortic aneurysms poses no problem. As Robicsek[15] has noted, their only hope of survival leads through the operating room. There are some things however, that through our own experience and the experience of others, we have found helpful in dealing with ruptured abdominal aortic aneurysms. First, one must impress upon emergency room physicians, general practitioners, and internists, who see these patients initially, that in a patient who is complaining of severe abdominal and/or back pain, and is clinically in shock, that they must examine the abdomen carefully for the presence of an expansile, pulsating abdominal mass. If this is found, then they should immediately notify a vascular surgeon. As others have noted, two large bore needles or intracaths should be inserted in the upper extremities, one of them, preferably, a central venous pressure catheter. Blood should be drawn at this time for type and crossmatch and for preliminary base line laboratory studies. A Foley catheter should be inserted in the bladder and attached to a urometer.

We have found that the G-Suit has been especially helpful and we recommend that the patient be placed on the G-Suit, but it not be applied unless the patient is extremely hypotensive, until the vascular surgeon is able to confirm the diagnosis. Then apply the G-Suit and take the patient immediately to the operating room. When the surgical team is assembled, the instruments prepared, and the blood is available, the patient is anesthetized and the endotracheal tube is inserted. A Levine tube is inserted at this time. Then the G-Suit is removed and the abdomen is prepared and draped rapidly and a long midline incision is made.

Upon exposing the ruptured aneurysm, there have been a number of methods in which proximal control may be gained. One is clamping the thoracic aorta through a left thoracotomy,[13] another is compressing the aorta at the level of the diaphragmatic area,[6] and a third is the use of the abdominal aortic compressor designed by the Pilling Corporation. However, we have found, in our hands, the best method is the intraluminal balloon tamponade first described by Hesse, et. al., in 1962. With manual compression of the aorta above the aneurysm, the aneurysm is opened widely and all the laminated thrombus is evacuated. A #30F 30 ml Foley catheter on a stylet is inserted proximally and the balloon is inflated. Following this, as described by Bradham, we insert small Foley catheters with 5 ml balloons distally into the iliacs and inflate them and clamp the catheters. With the bleeding controlled, one can dissect the neck carefully and gain proximal control and remove the proximal Foley catheter. Then, the operation can proceed as a usual resection of an aneurysm. Prior to gaining proximal control, we try to give as little intravenous fluid or blood as is possible,

Number of Transfusions

	Not Ruptured (36 patients)	Ruptured (13 patients)
Total Number	130 Units	122 Units
Average	3.8 Units	9.4 Units
Range	0-11 Units	2-16 Units

* Units Mean 500 ml

because of the possible aggravation of the rupture and bleeding. During the early stages, we give 12.5 gm of Mannitol intravenously and usually 80 mg of Furosemide intravenously to attempt to minimize renal damage produced by shock. In addition, as soon as the aorta is clamped, then we transfuse rapidly. At the end of the procedure, we declamp gradually. If the patient has been in shock, we give him 1 to 2 ampules of Sodium Bircarbonate in an attempt to minimize the metabolic acidosis produced by the shock and the distal anaerobic metabolism during aortic clamping.

In contradistinction to elective aneurysmal surgery, we do not ordinarily give intravenous Heparin. Instead, we rely on flushing of the distally placed Foley catheters with Heparinized saline.

Post-operatively we tend to keep the endotracheal tube in place for the first 24 hours with the patient on ventilatory assist. Immediately postoperative, we check the blood volume and if there is a deficit in red cell volume, we transfuse with packed red blood cells to normal levels. Urine output is maintained at 30 to 50 ml per hour with intravenous fluids. The central venous pressure is monitored hourly. If the urine output drops off, we challenge the patient with rapid infusion of 200-300 ml of intravenous fluid. If the CVP rises, we assume that there is adequate blood volume. We then give Furosemide, Mannitol and adequate intravenous fluids to maintain a satisfactory urine output. If despite this urine volume tends to drop off, then we assume that there has been acute tubular necrosis and drastically restrict fluids. We maintain close liason with the renal unit at Presbyterian University Hospital in Pittsburgh. If the serum potassium and/or blood urea nitrogen tends to rise, we transfer the patient to Presbyterian University Hospital for insertion of a Scribner shunt and hemodialysis, if indicated.

The decision as to operative or nonoperative management of an unruptured aneurysm is somewhat more difficult, but rapidly becoming less so. In assessing this problem, the question that must be answered is whether or not the operative mortality is greater than the chance of dying of rupture of the aneurysm. Starting with the classic series of Estes[7] and many others, Foster, et. al.,[9] Roberts, et. al.,[14] and particularly Szilagyi,[17] there is no question that the patient whose aneurysm is resected has a two times better chance of surviving five years than the patient who is not operated upon. We agree with the consensus in the literature, that all patients with abdominal aortic aneurysms should be operated upon with the following exceptions as quoted from Bergan, et.al.[2]

1. Acute myocardial infarctions
2. Intractable congestive heart failure
3. Intractable angina pectoris
4. Severe pulmonary insufficiency
5. Chronic renal insufficiency with blood urea nitrogen higher than 80 mgm. per 100 ml.
6. Associated fatal disease with less than 2 years' life expectancy

In elective aneurysms, we also handle this via a long midline abdominal incision. Following careful abdominal exploration, we place the small bowel in a plastic Leahy bag and take it out of the abdominal cavity to the right. A long retroperitoneal incision is made over the aneurysmal mass and proximal and distal control are obtained.

Following this, approximately 5,000 units of Heparin are given intravenously and the aorta is then clamped about 3 minutes later. The aneurysm is opened wide anteriorly and the laminated clot is evacuated. Following this two small Foley catheters are inserted distally and inflated and attached to syringes with Heparinized saline in them.

If there is bleeding from the lumbar arteries, these are suture ligated. The aorta is usually completely transected proximally and an end to end anastomosis is carried out with two continuous sutures of 3-0 Prolene starting in the midline posteriorly. Following completion of the proximal anastomosis, flush is carried out in order to get rid of any loose debris and then either a distal aortic or distal iliac anastomosis is made depending on whether it is necessary to go into the iliacs or not. We have used 20 bifurcated grafts and 27 cylinder grafts.

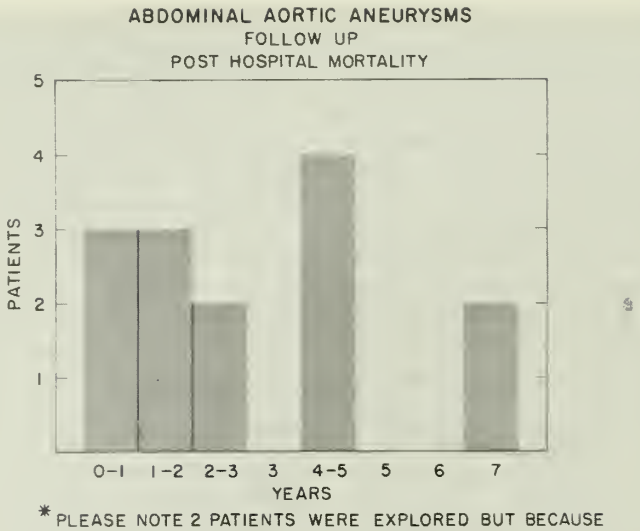
Prior to completion of the distal anastomosis, a distal and proximal flush is carried out and then the anastomosis is completed after removing the distal Foley catheters. Declamping is carried out slowly. At the same time, either blood or intravenous fluid is rapidly infused. The aneurysmal wall is then trimmed and closed over the graft and then the posterior peritoneum is closed with a continuous chromic catgut suture.

Complications

Of the patients who survived operation, 18 were free of complications. In the survivors, 5 developed complications involving the respiratory system, either pneumonitis,

Hospital Mortality

	Not Ruptured (36 patients)	Ruptured (13 patients)
Myocardial Infarction		2
Cerebravascular Accident	1	
Bilateral Renal Artery Thrombosis		1
Irreversible Shock		2
Pulmonary Embolism	1	
Cardiac Arrhythmia		1
Renal Shutdown		2
TOTAL	2	8
Mortality	5.5%	62%



* PLEASE NOTE 2 PATIENTS WERE EXPLORED BUT BECAUSE OF INVOLVEMENT OF THE RENAL ARTERY WERE TRANSFERRED TO PRESBYTERIAN UNIVERSITY HOSPITAL WHERE THEY SUBSEQUENTLY DIED FOLLOWING SURGERY.

atelectasis or retained secretions; 3 patients developed cardiac arrhythmias; 2 had either distal thrombosis or embolization necessitating one above the knee and one below the knee amputation. Of the patients, 2 had massive upper gastrointestinal hemorrhage that responded to conservative management; 1 patient developed acute tubular necrosis and and had to be transferred for hemodialysis.

Results

The immediate operative mortality in patients with ruptured abdominal aortic aneurysm was 62 percent while mortality for elective resection was 5.5 percent. The high mortality among those with ruptured aneurysm were sequellae of hypovolemic shock, i.e., irreversible shock, myocardial infarctions and/or acute tubular necrosis. Causes of death in 2 patients who had elective surgery were massive cerebral thrombosis and acute pulmonary emboius; 2 patients were explored but because of involvement of the renal arteries, were not resected. They were transferred to Presbyterian University Hospital in Pittsburgh.

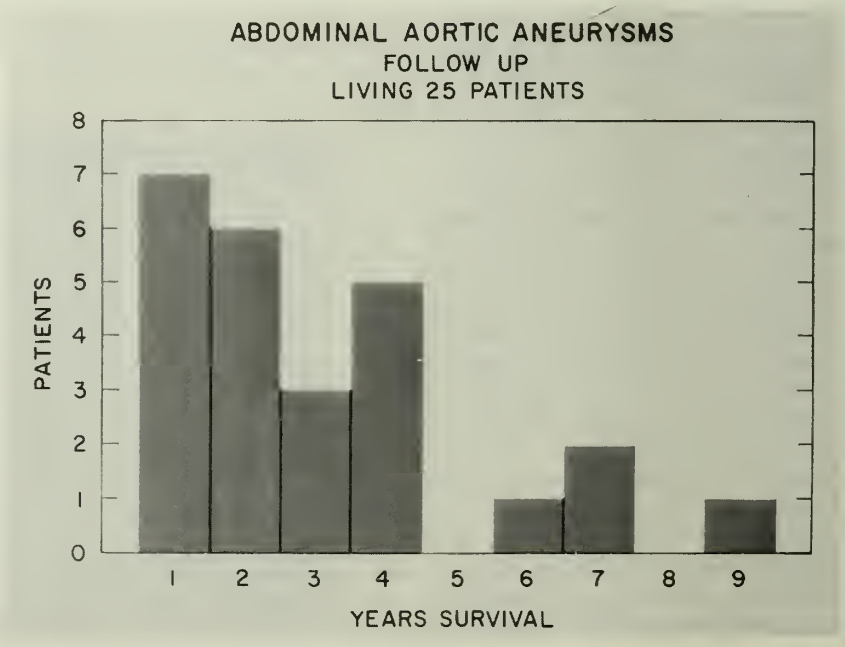
Discussion

The problem that is most pressing is the inordinate mortality in patients with ruptured abdominal aortic aneurysms. We have several suggestions as to how to attack this problem.

First, eliminate ruptured abdominal aneurysms. We know that this is impossible, but how can we decrease the incidence of its occurrence? With the emphasis on continuing medical education, we would suggest that programs geared to physicians who do routine health examinations stress the need for careful abdominal examination, especially in men over 50 years old. In all series, an expansile, pulsating, abdominal mass is found in a high percentage of patients. The importance of elective resection should be stressed.

Second, make the diagnosis of a ruptured aortic aneurysm. As Chung[4] at the Vancouver General Hospital has pointed out, ruptured abdominal aneurysm continues to be a diagnostic problem. It is a problem because of (1) failure to take a good history as to the origin and radiation of pain, (2) failure to recognize the various sites and radiation of pain that may be associated with ruptured aneurysm and with the subsequent dissection of the hematoma, and (3) failure to perform an adequate physical examination to detect the finer signs of compensated shock or to discover a tender, pulsatile mass that is present in virtually every case of ruptured abdominal aortic aneurysm.

Third, operate upon the patient with the ruptured abdominal aneurysm in his own community hospital. One of the major causes in the high mortality is the time delay when a patient is transferred from the community hospital to a university medical center. Evans[8], in his experience at Ohio State University Hospital noted that 37 of 42 patients, in their series of ruptured abdominal aortic aneurysms, were transferred from hospitals outside the Columbus area. If elective vascular surgery is performed in the community hospital, then surgeons will gain experience on handling the patient with a ruptured abdominal aortic aneurysm and hopefully decrease the mortality.



Conclusion

We have reviewed our experience with 49 patients operated upon for abdominal aortic aneurysm in a community hospital. Our operative mortality compares favorably with other published series. In order to decrease the inordinate death rate from ruptured aneurysms, we have suggested that programs in continuing medical education emphasize (1) the need for careful abdominal examination in men over 50 years of age in order to find aortic aneurysms and then refer them for elective surgery, (2) the need to think of ruptured abdominal aortic aneurysm in patients over 50 years of age, complaining of abdominal pain, who are clinically in shock, and finally, (3) that surgery for abdominal aortic aneurysm should be carried out in the community hospital so that patients with ruptured aneurysms will not need to be transferred to university centers, thus delaying surgery and increasing the mortality. ☐

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obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Joseph E. Beideman,** Norristown; University of Pennsylvania School of Medicine, 1919; age 79; died March 18, 1975. He was past president of the Montgomery County Medical Society and had practiced medicine for over 50 years. He was one of the early diplomates of the American Board of Ophthalmology and a fellow of the American Academy of Ophthalmology and Otolaryngology. His wife, a sister, niece, and nephew survive him.

• **Alvin Berkowitz,** Oreland; University of Pennsylvania School of Medicine, 1959; age 41; died April 13, 1975. He is survived by his wife, two daughters, a son, mother, father, and sister.

• **Harry W. Bernhardy,** Beaver Falls; University of Pittsburgh School of Medicine, 1909; age 89; died April 12, 1975. He was a founder of the American College of Surgeons and the Beaver County Cancer Society. His wife, two sons and a daughter survive him.

• **Edgar W. Kemmer,** St. Petersburg, Florida; Jefferson Medical College, 1917; age 87; died April 12, 1975. He is survived by several nieces and nephews.

• **Henry Kozloff,** Allentown; University of Pennsylvania School of Medicine, 1940; age 62; died March 20, 1975. He was medical director of the Reuben Block Health Fund and received the alumni award of merit from the University of Pennsylvania in 1969. Surviving are his wife, two sons, one of whom is Louis Kozloff, M.D., a daughter, four sisters and two brothers.

• **Francis B. Markunas,** Camp Hill; Jefferson Medical College, 1940; age 60; died April 21, 1975. He was director of medicine, chief of the radiology department, and director of the School of Radiological Technology. He was a member of the American College of Radiology, the Radiological Society of North America, Pennsylvania Radiological Society, the Philadelphia Roentgen Ray Society, and the Harrisburg Academy of Medicine. He is survived by his wife, eight daughters, a son, his mother, and four sisters.

• **Robert Harold Miller,** Pittsburgh; University of Pittsburgh School of Medicine, 1942; age 61; died April 2, 1975. Two sisters survive him.

• **R. Charles Nucci,** Pittsburgh; University of Pittsburgh School of Medicine, 1922; age 77; died April 11, 1975. A son survives him.

• **Benjamin Strawbridge Perkins,** Erie; Jefferson Medical College, 1946; age 55, died March 17, 1975. He is survived by his wife.

• **Lloyd S. Persun, Jr.,** Camp Hill; Temple University School of Medicine, 1940; age 60; died April 17, 1975. He was chief and coordinator of otorhinolaryngology at Polyclinic Hospital, Harrisburg, where he was past president of the medical staff. He was a past president of the Dauphin County Medical Society and a clinical instructor at Hahnemann Medical College. He was a diplomate of the American Board of Otorhinolaryngology and a fellow of the American College of Surgeons. His wife, three sons, his mother, and a sister survive him.

• **John A. Ratnavale,** Pittsburgh; University of Ceylon, 1951; age 50; died April 10, 1975. His wife and two sons survive him.

• **Robert McDonald Rylands,** Pittsburgh; Georgetown University School of Medicine, 1930; age 69; died March 17, 1975. He is survived by his wife, father, a son, and daughter.

• **John T. Szypulski,** Fayetteville; University of Pennsylvania School of Medicine, 1939; age 64; died April 18, 1975. He was a member of the American Society for Chest Diseases, Pennsylvania Pulmonary Society, and on the executive board of the Pennsylvania Lung Association. Surviving are his wife, Helen Tananis Szypulski, M.D., four sisters, and a brother.

• **John D. Trevaskis,** Brielle, N.J.; Jefferson Medical College, 1925; age 82; died February 26, 1975. He is survived by his wife and a daughter.

• **Richard F. Turner,** Philadelphia; University of Pennsylvania, 1951; age 49; died March 10, 1975. He was director of family medicine at Jeanes Hospital and medical director of the Baptist Home. His wife, a son, daughter, and a sister survive him.

• **Lotzi J. Vercusky,** Freeland; Temple University School of Medicine, 1932; age 76; died April 17, 1975. He was past president of the Hazleton Branch of the Luzerne County Medical Society. Surviving are his wife, a daughter, a brother, and a sister.

Louis J. C. Bailey, Jr., Greensburg; University of Michigan Medical School, 1933; age 73; died March 24, 1975. His widow and two daughters survive him.

W. Wendel Becker, Reading; Jefferson Medical College, 1919; age 84; died April 4, 1975. A sister survives him.

George F. Crothers, Marcus Hook; University of Pennsylvania School of Medicine, 1910; age 89; died March 2, 1975. He is survived by three daughters.

William P. Dodds, Harrisburg; Columbia University College of Physicians and Surgeons, 1917; age 85; died April 3, 1975. A sister survives him.

William M. Eboch, Jr., Mechanicsburg; Jefferson Medical College, 1968; age 32, died March 12, 1975. His wife, a daughter, his parents, a sister, and a grandmother survive him.

Edward L. Keyte, Willow Grove; University of Pennsylvania School of Medicine, 1927; age 74; died March 12, 1975. He had practiced medicine for over 42 years. His wife, two sons, and a daughter survive him.

Leon S. Smelo, Pittsburgh; University of Pennsylvania School of Medicine, 1934; age 64; died March 18, 1975. His wife, a daughter, and sister survive him.

Stanley M. Winter, Nanticoke; Jefferson Medical College, 1915; age 86; died March 28, 1975. Surviving are a son, a sister, and two nieces.

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House of Delegates meets on July 2 and 3 in special session on Malpractice

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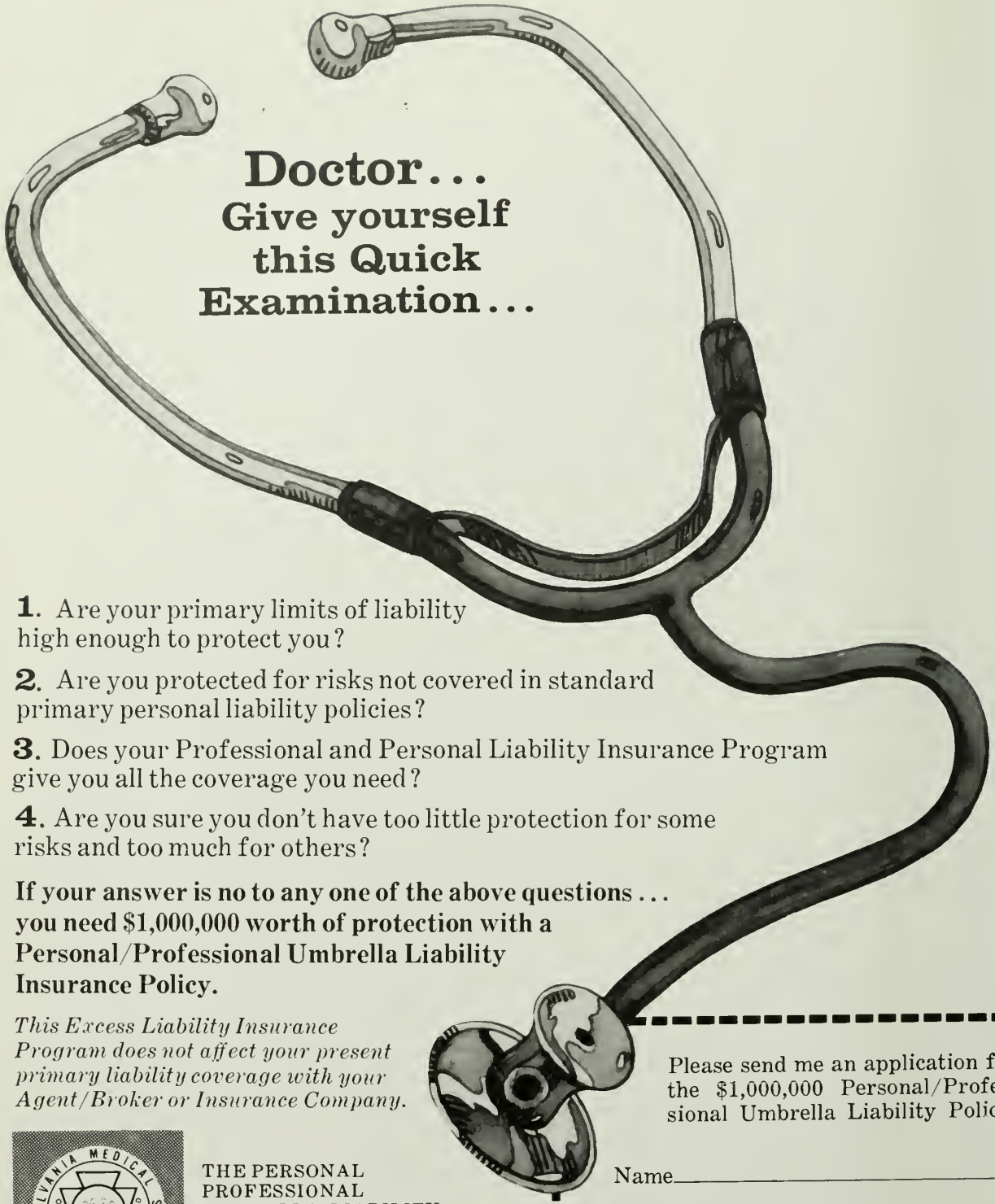

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SPECIAL HOUSE SESSION IN RECESS The House of Delegates of the Pennsylvania Medical Society stands in recess after having rejected a number of resolutions calling for statewide restriction of medical services.

After a special session held July 2 and 3 at the Penn Harris Motor Inn, Harrisburg, the House recessed in order to meet on short notice should the Legislature fail to enact corrective legislation concerning the malpractice insurance crisis.

The House defeated seven resolutions dealing with the physician slowdown as "...physicians find the concept of restricting services contrary to the traditional principles of medical ethics." A substitute resolution was adopted which states that the "special session... be reconvened to give serious consideration to the matter of a statewide slowdown at the appropriate time." Also authorized, if the Board of Trustees sees the need, is a mass demonstration in Harrisburg.

More attention was given by the delegates to the various alternatives to a slowdown. The House adopted a suggestion made by A. Reynolds Crane, M.D., Society president, in his opening address that until "significant legislation is enacted," physicians use a written agreement, signed prior to accepting the patient, which states that if the patient is dissatisfied with the results of the treatment, then he must submit his case to arbitration for settlement. The agreement covers claims of negligence, malpractice, tort, or breach of contract and is final unless the patient gives written notification within thirty days of signing.

Another of Dr. Crane's recommendations that was adopted by the House is the use of the Medical Defense Fund "to cover the legal costs of any meritorious 'abuse of process' case on behalf of physicians who have successfully defended against a malpractice charge." An assessment of the membership will be determined by the Board of Trustees and Councilors to cover this and other expenses connected with the malpractice struggle.

Dr. Crane also suggested that the Society declare it unethical for a physician to accept a fee for medical testimony and set up a system through which medical testimony will be furnished as a "friend of the court" but not on an adversary basis. This was referred to the Judicial Council for consideration.

The House adopted resolutions that the Society study possibilities for further action and begin now to develop a plan for emergency care in the event of a restriction of services in the future.

During the July 2 reference committee hearing, much discussion took place concerning premium rollbacks. The five resolutions concerning rollbacks ranged from seeking an injunction to filing complaints and requesting authorities to roll back premiums to levels existing prior to April 1, 1975. The House referred those resolutions July 3 and directed the Board of Trustees to restudy the justification of the rate structure and report to the House at the October session.

ASSISTANTS MEETING SCHEDULED Pennsylvania Blue Shield is conducting a series of meetings to explain Blue Shield procedures to doctors' office assistants, and to educate them in expediting claims submissions. At its May meeting the State Society's Board of Trustees recommended that members send their assistants to the meetings and assist in their financing. Meetings scheduled in August are:

August 6, 9 a.m., Mountain View Unit, Centre County Hospital, State College
August 6, 10 a.m., Holiday Inn, Bristol
August 6, 10 a.m., Downtowner Motor Inn, Erie
August 7, 9 a.m., DuBois Hospital, 100 Hospital Avenue, DuBois
August 8, 9:30 a.m., Citizens General Hospital, New Kensington
August 13, 9 a.m., Lewistown Hospital, Lewistown
August 13, 10 a.m., Downingtown Motor Inn, Downingtown
August 20, 8:30 a.m., Evangelical Community Hospital, Lewisburg
August 20, 10 a.m., Howard Johnson's Motor Inn, Chester
August 27, 9 a.m., Sunbury Community Hospital, Sunbury
August 27, 10 a.m., Valley Forge Hilton, King of Prussia

INTERIM APPROVAL REQUIRED FOR ABORTIONS Regulations requiring Department of Health approval of facilities where abortions are performed are in effect following the lifting of parts of the injunction which has prevented implementation of Act 209, the Abortion Control Act. The regulations cover all health care facilities where abortions are performed, including physician's offices, which were specifically excluded in earlier Health Department rules for ambulatory gynecological surgery. Interim approval must be obtained while the approval process is proceeding. For interim approval and further information contact Alvin Tucker of the Division of Maternal and Child Health, Pennsylvania Department of Health, by telephoning (717) 787-7436.

PLAN A TO BE DISCONTINUED Pennsylvania Blue Shield's Plan A Medical Surgical Agreement will be discontinued December 31, 1975. The action is in compliance with an Insurance Department directive issued because of outdated fee schedule allowances and income limits. Blue Shield ceased to promote the sale of Plan A in 1970, but some 113,000 subscribers still have Plan A coverage, and will be contacted before the end of the year for coverage conversion.

USP APPOINTMENTS MADE The Board of Trustees in May named Arthur H. Hayes, M.D., of Hershey, to serve as delegate to the U.S. Pharmacopeial Convention. Dr. Hayes is chairman of the Society's Commission on Therapeutics. David A. Smith, M.D., medical editor of PENNSYLVANIA MEDICINE was appointed alternate delegate. See page 17 for information on further U.S.P. activities.

SOCIETY ASSISTS IN PUBLIC HEALTH The State Society's Communication Division is assisting the Department of Education educate the public on the state's new immunization requirements for school children through taped spot announcements whic have been sent to all radio stations. The requirements are that befor entering school this fall children must have certain immunizations. They are: diphtheria; tetanus; types one, two, and three poliomyelitis measles: and rubella.

pennsylvania medicine

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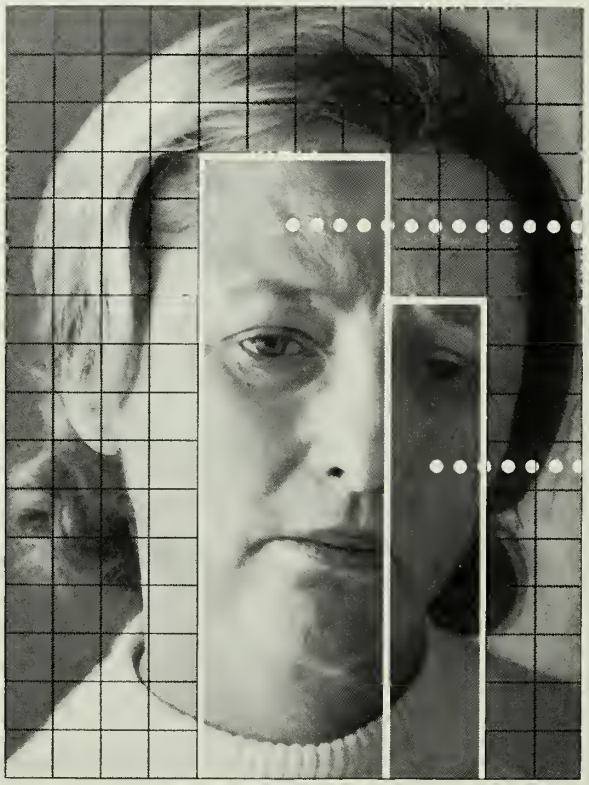

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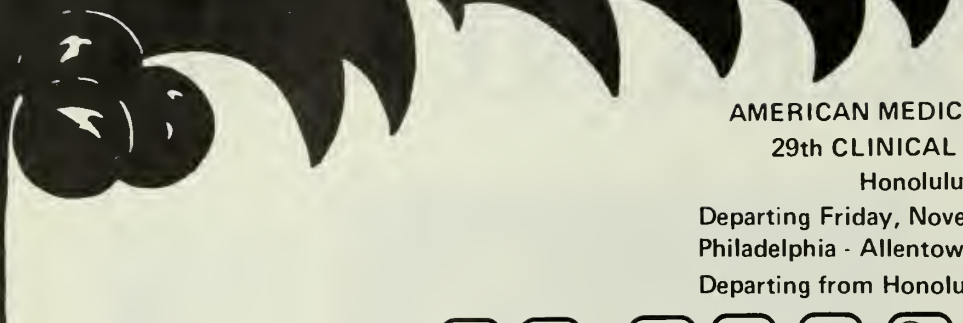

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PHONE _____ DEPARTURE CITY _____

Names of Accompanying Family Member's (Please give children's ages)

_____

_____

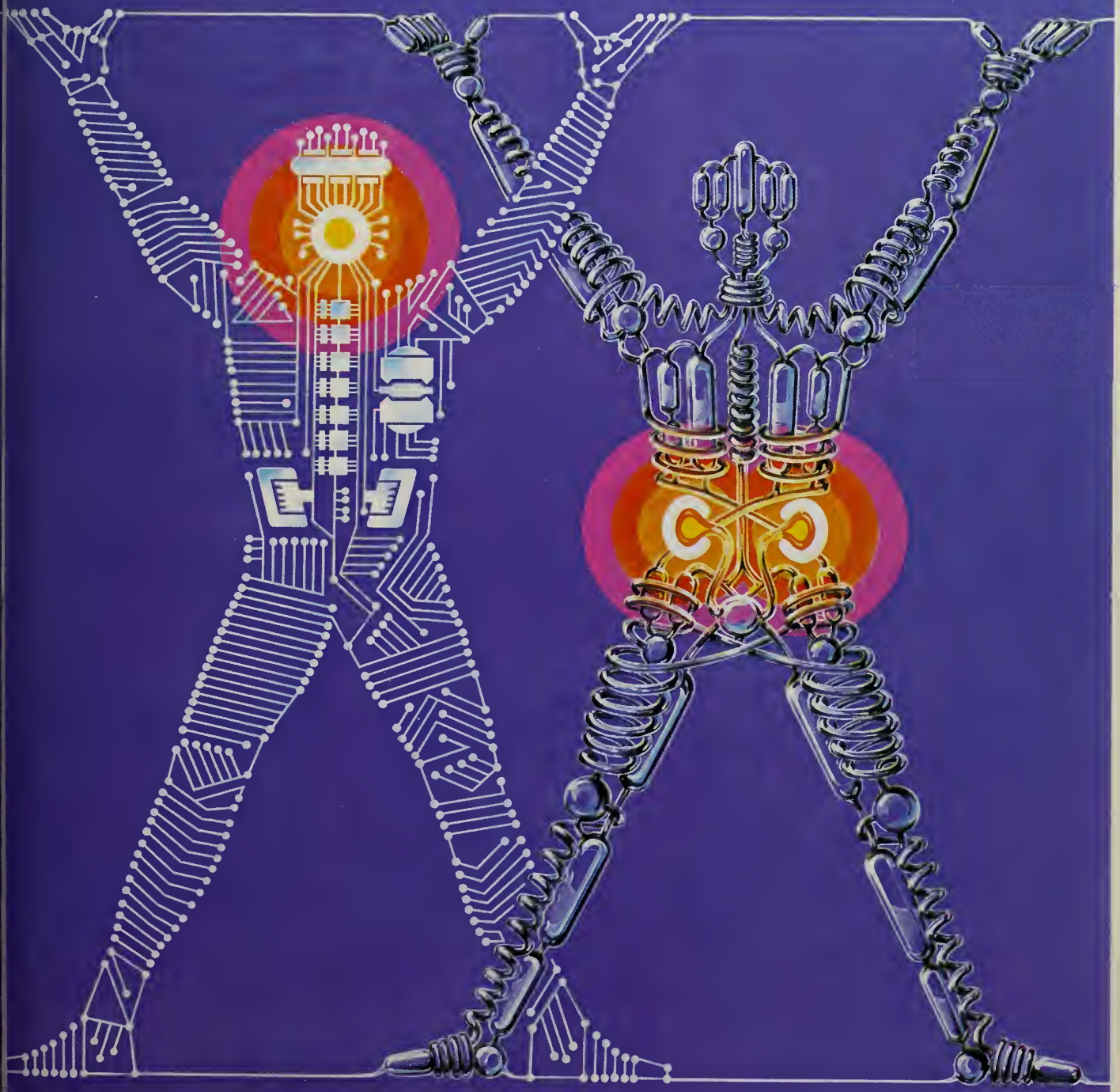
For further information call **800-621-1046** Toll Free

Announcing nonreserpine Combipres®

Each tablet contains: Catapres®, brand of clonidine hydrochloride, 0.1 or 0.2 mg and chlorthalidone, 15 mg

The only major new combination antihypertensive in a decade

ease see last page of advertisement
a brief summary of the prescribing information
cluding precautions, warnings, and
verse reactions.



nonreserpine

new Combipres®

Each tablet contains:
Catapres®, brand of clonidine hydrochloride,
0.1 or 0.2 mg and chlorthalidone, 15 mg

.1 and .2

Catapres®
(clonidine hydrochloride)
contributes:

Action at the vasomotor centers, as shown in animal studies—not a rauwolfia derivative or a sympathetic blocker or a "false transmitter"

Maximal blood pressure lowering without the weeks of delay common with the rauwolfia class of antihypertensives

Significant blood pressure reduction without alteration of normal hemodynamic responses to exercise

Mild and infrequent orthostatic hypotension

Little or no change in renal blood flow and glomerular filtration rate

Reduced plasma renin activity and excretion of aldosterone and catecholamines (see Actions section)

Combines Catapres (clonidine hydrochloride) with a diuretic—the only major new combination antihypertensive in a decade

Chlorthalidone contributes:

Pharmacologic action similar o the thiazides

Smooth, extended diuretic/ antihypertensive effect

Additive or potentiating effect on adjunctive antihypertensive agents

he most common adverse reactions with ombipres are dry mouth, drowsiness, and edation. As with thiazide-containing combi- ation antihypertensives, hypokalemia, hyper- icemia, and decreased glucose tolerance ay occur. Combipres is contraindicated in atients with known sensitivity to chlorthali- one and in those with severe renal or hepatic isease.

lease see last page of advertisement for a rief summary of the prescribing information cluding precautions, warnings, and adverse eactions.

ee box Warning on next page concerning e appropriate use of Combipres.

nonreserpine

new Combipres®

Each tablet contains:
Catapres®, brand of clonidine hydrochloride,
0.1 or 0.2 mg and chlorthalidone, 15 mg

.1 and .2

Works harder

Usually exerts a more pronounced antihypertensive effect than either component alone in equivalent doses*

Works broadly

Wide therapeutic range—mild to severe hypertension

Works conveniently

Simplifies therapy for the hypertensive patient who needs more than one drug*

Works for less

Costs less than two separate prescriptions*

Works and works and works

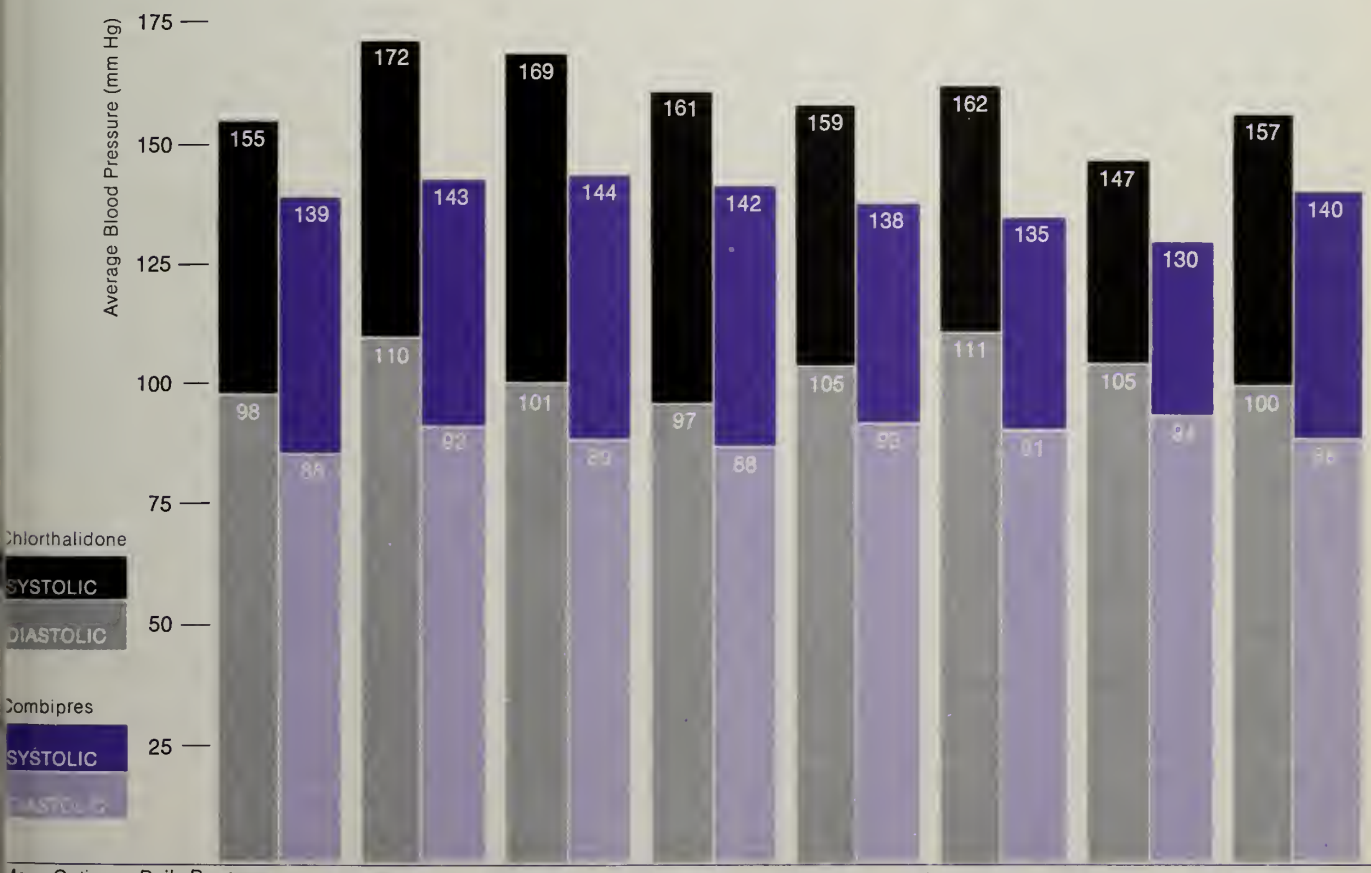
Convenience and economy encourage patients to stay on medication, help assure continued blood pressure control over the long course of therapy*

*__WARNING__ Combipres is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

The only major new combination antihypertensive in a decade

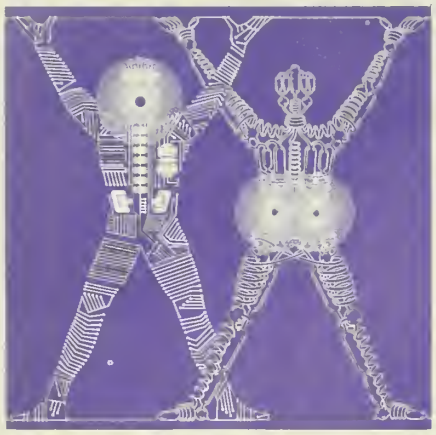
Works in the majority of hypertensive patients

Chlorthalidone vs Combipres
A Comparison of Standing Blood Pressure Response in 8 Studies



Mean Optimum Daily Dose Chlorthalidone (mg)	50	50	47.7	50	50	50	71	50
Combipres (mg)	0.3	0.48	0.47	0.4	0.43	0.68	0.52	0.4
No. of Patients who completed study	42	20	11	17	34	9	31	9
Study	1	2	3	4	5	6	7	8

Please see last page of advertisement for a brief summary of the prescribing information including precautions, warnings, and adverse reactions.



nonreserpine

new Combipres®

Each tablet contains: Catapres®, brand of clonidine hydrochloride, 0.1 or 0.2 mg and chlorthalidone, 15 mg

Guidelines for Titrating Catapres and Chlorthalidone Dosages:
Initial doses: Catapres—one 0.1 mg tablet twice daily. Chlorthalidone—50 mg daily.

Dosage increments: While daily chlorthalidone doses remain at 50 mg, further increments of Catapres of 0.1 mg or 0.2 mg per day can be made at intervals of 2 to 14 days depending on severity of hypertension. The usual daily dose of Catapres ranges between 0.2 and 0.8 mg. Studies indicate that 2.4 mg is the maximum effective daily dose, but doses as high as this have rarely been used.

Combipres®

Each tablet contains:
Catapres®, brand of clonidine hydrochloride, 0.1 or 0.2 mg and chlorthalidone, 15 mg

WARNING: This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

Actions: Catapres (clonidine hydrochloride): The mechanism of action appears to be central alpha-adrenergic stimulation as demonstrated in animal studies. This results in inhibition of bulbar sympathetic cardioaccelerator and sympathetic outflow from the brain. Other studies in humans have provided evidence of a reduction in plasma renin activity and the excretion of aldosterone and catecholamines. The exact relationship between these pharmacologic actions of Catapres (clonidine hydrochloride) in humans and its antihypertensive effect has not been fully elucidated at this time.

Chlorthalidone: The diuretic action of chlorthalidone is thought to be due to inhibition of sodium and chloride reabsorption in the proximal tubule.

Indication: The drug is indicated in the treatment of hypertension (see box warning).

Contraindications: Patients with known hypersensitivity to chlorthalidone and patients with severe renal or hepatic diseases.

Warnings: Tolerance may develop in some instances necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxicity findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefit outweighs the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Combipres in children.

Precautions: When discontinuing Combipres, reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of Combipres therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect of the clonidine hydrochloride component. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other antihypertensive agent, Combipres should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Combipres should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmological findings have been recorded with Catapres, in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Patients predisposed toward or affected by diabetes should be tested periodically while receiving Combipres, because of the hyperglycemic effect of chlorthalidone.

Because of the possibility of progression of renal failure, periodic determination of the BUN is indicated. If, in the physician's opinion, a rising BUN is significant, the drug should be stopped.

The chlorthalidone component of Combipres may lead to sodium and/or potassium depletion. Muscular weakness, muscle cramps, anorexia, nausea, vomiting, constipation, lethargy or mental confusion may occur. Severe dietary salt restriction is not recommended in patients receiving Combipres.

Periodic determinations of the serum potassium level will aid the physician in the detection of hypokalemia. Extra care should be given to detection of hypokalemia in patients receiving adrenal corticosteroids, ACTH or digitalis. Hypochloremic alkalosis often precedes other evidence of severe potassium deficiency. Frequently, therefore, more sensitive indicators than the potassium serum level are the serum bicarbonate and chloride concentrations. Also indicative of potassium depletion can be electrocardiographic alterations such as changes in conduction time, reduction in amplitude of the T wave; ST segment depression; prominent U wave. These abnormalities may appear with potassium depletion before the serum level of potassium decreases. To lessen the possibility of potassium deficiency, the diet, in addition to meat and vegetables, should include potassium-rich foods such as citrus fruits and bananas. If significant potassium depletion should occur during therapy, oral potassium supplements in the form of potassium chloride (3 to 4.5 gm/day), fruit juice and bananas should be given.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy.

Clonidine hydrochloride: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one case of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash; impotence, urinary retention; increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Chlorthalidone: Symptoms such as nausea, gastric irritation, anorexia, constipation and cramping, weakness, dizziness, transient myopia and restlessness are occasionally observed. Headache and impotence or dysuria may occur rarely. Orthostatic hypotension has been reported and may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics. Skin rashes, urticaria and purpura have been reported in a few instances.

A decreased glucose tolerance evidenced by hyperglycemia and glycosuria may develop inconsistently. This condition, usually reversible on discontinuation of therapy, responds to control with antidiabetic treatment. Diabetics and those predisposed should be checked regularly.

As with other diuretic agents hypokalemia may occur (see Precautions). Hyperuricemia may be observed on occasion and acute attacks of gout have been precipitated. In cases where prolonged and significant elevation of blood uric acid concentration is considered potentially deleterious, concomitant use of a uricosuric agent is effective in reversing hyperuricemia without loss of diuretic and/or antihypertensive activity.

Idiosyncratic drug reactions such as aplastic anemia, thrombocytopenia, leukopenia, agranulocytosis, and necrotizing angiitis have occurred, but are rare.

The remote possibility of pancreatitis should be considered when epigastric pain or unexplained gastrointestinal symptoms develop after prolonged administration.

Other adverse reactions which have been reported with this general class of compounds include: jaundice, xanthopsia, paresthesia and photosensitization.

Overdosage: ***Catapres (clonidine hydrochloride):*** Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals abolishes all effects of Catapres overdosage.

Chlorthalidone: Symptoms of overdosage include nausea, weakness, dizziness, and disturbances of electrolyte balance. There is no specific antidote, but gastric lavage is recommended, followed by supportive treatment. Where necessary, this may include intravenous dextrose and saline with potassium administered with caution.

How Supplied: Combipres® 0.1 (Each tablet contains clonidine hydrochloride, 0.1 mg + chlorthalidone, 15 mg). It is available as pink, oval, single-scored compressed tablets in bottles of 100.

Combipres® 0.2 (Each tablet contains clonidine hydrochloride, 0.2 mg + chlorthalidone, 15 mg). It is available as blue, oval, single-scored compressed tablets in bottles of 100.

For complete details, please see full prescribing information.

References: 1. Becker, M. C.: Data on file at Boehringer Ingelheim Ltd. **2.** Belle, M. S.: Data on file at Boehringer Ingelheim Ltd. **3.** Hall, B. H.: Data on file at Boehringer Ingelheim Ltd. **4.** McDonald, R. L.: Data on file at Boehringer Ingelheim Ltd. **5.** Parsons, W. B., Jr.: Data on file at Boehringer Ingelheim Ltd. **6.** Russell, R. P.: Data on file at Boehringer Ingelheim Ltd. **7.** Winemiller, R. H.: Data on file at Boehringer Ingelheim Ltd. **8.** Yeh, B.: Data on file at Boehringer Ingelheim Ltd.

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president's page

Dr. Crane testifies before Judiciary Committee

I am Dr. A. Reynolds Crane, President of the Pennsylvania Medical Society. With your permission, I would like to give you a little bit of my background. I am Professor of Pathology emeritus at the University of Pennsylvania School of Medicine, consultant to the Ayer Clinical Laboratory at the Pennsylvania Hospital where for many years I served as Director, and a Senior Member of the Institute for Cancer Research in Fox Chase. For a number of years I was Chairman of the Medical Legal Committee of the Philadelphia County Medical Society and wrote and ran the panel plan for the assessment of alleged instances of medical malpractice which operated in that county. I have also served as Chairman of the Medical Legal Committee of the Pennsylvania Medical Society and with Judge Van Dusen of the Federal Court developed an impartial medical testimony plan which operated in that court. I mention these things to indicate that while as a pathologist I am relatively removed from the front line of the fire, I have had broad experience with the medical legal aspects of medical practice and have been much concerned about them for many years.

Gentlemen, I throw out to you today a challenge. The challenge is to see that meaningful legislation is put on the floor of the House promptly - within the week. House Bill 1367 is *NOT* meaningful legislation and I will tell you why. First let me say that by even considering it you are exacerbating the situation. By recommending it you will precipitate this state into the worst crisis in medical care it has ever known—even worse than the present one.

While the bill offers no solutions it does define the problem in its preamble.

Section 102 of the bill under the heading "Legislative Findings" describes a Pennsylvania malpractice insurance climate all too familiar to physicians. It cites the rising number of suits and claims for damages. It reports that the size of judgments and settlements has increased substantially. It finds that insurance companies have raised premiums as a reaction to all this. We have experienced these facts first-hand and are in agreement. It is also true, as the bill asserts, that insurance companies view medical malpractice insurance as unprofitable, and doctors an uninsurable risk. And we can even add Lloyds of London. The result is that companies are falling over each other in their rush to leave the medical malpractice insurance business. This is particularly true of insuring the high risk medical specialties, such as anesthesiology and orthopedics.

House Bill 1367 claims that the growing number of suits leads to the practice of "defensive medicine" and that physicians tend to view patients as potential adversaries. Members of the Pennsylvania Medical Society have written to me and confirmed this. Here is what a doctor from the western part of the state wrote: "Defensive medicine is the order of the day for everybody, including practitioners working here for more than fifty years." Another doctor from the center of the state writes: "One of the problems that we see now is the large number of laboratory studies and x-rays that are being performed only because we are afraid of malpractice suits, not because they are useful for the diagnosis and treatment of the patient's disease." At the national level it has been estimated that health costs are being needlessly inflated by $3 - 7 billion (Caspar Weinberger) a year just on the issue of defensive medicine. And then there is the psychological impact of defensive medicine. Of always looking over our shoulders. Is this the climate in which trust can be built up between doctor and patient, when the law makes them view each other as adversaries? I think not.

House Bill 1367 finds that the difficulty and high cost of obtaining insurance discourages young physicians from entering practice in the Commonwealth. We know that it not only discourages them, it prevents them from practicing in Pennsylvania. Already burdened with debt from medical school and residency, in no way can they pay a $15,000 (or more) insurance premium before seeing their first patient, if indeed insurance is available at all. The malpractice insurance crisis in Pennsylvania is driving young doctors away.

Nor is this solely a doctor problem. An increasing number of hospitals in Pennsylvania have been hurt. In Philadelphia, hospital malpractice insurance premiums now run from $5 to $15 per patient day. Hospitals have experienced rate hikes of 300 percent or more. These costs, which show up in our Blue Cross plans, will eventually impact on employers and employees across the state in the form of higher insurance premiums. Only in this instance, very little of those premiums will be returned in the form of benefits to those who paid. A comparative handful of plaintiffs in malpractice suits will collect and even they will get precious little of that money. Most of it, an estimated 84 cents out of every premium dollar, goes to keeping the system alive—plaintiff's attorneys, defense attorneys, insurance company ad-

ministrative costs and profits and the courts themselves. Hardly a good buy compared to Blue Shield which returns about 90c to subscribers.

House Bill 1367 states that some doctors have been forced to curtail their practices because of the high cost of malpractice insurance. And indeed this is true. Here is what one physician wrote to me, "If it goes much higher, (Malpractice insurance) I will have to drop services to the public. I am 64 and have some years to practice yet but if necessary I shall stop, and then the community and hospital will be harder pressed, as I am the main eye, ear, nose and throat staff member." A general practitioner writes, "I see no way that I can continue in the practice of medicine if I have to raise my fee schedule to cope with the rise of malpractice insurance. My patients are country folks and cannot afford a raise in fees. The medical profession is already being criticized for the excessive costs. I am presently 65 and take care of an active GP practice and my patients will suffer if I leave." An Ob-Gyn specialist from Philadelphia told me just one week ago that he had planned to gradually phase out of practice over the next several years, but all that has changed now. When he gets his premium notice for over $20,000 this December he will quit. There is no way, by limiting his practice, that he can generate the kind of money. He is being squeezed out and his patients will lose their physician.

Section 102 concludes by stating that, "The cumulative effect of suits and claims is working to the detriment of both the health care providers and the citizens of the Commonwealth." With this statement we are in complete accord.

You, your committee, and the Legislature must accept these findings, for any testimony you will hear to the contrary will come from trial lawyers or the Trial Lawyers Association. These people will tell you that there is no such thing as a malpractice crisis, that Pennsylvania doctors are merely being ripped-off by an insurance company, and that this is an insurance company problem alone.

Such is not the case. If simply one insurance company caused the problem, then the solution would be equally simple. The fact remains, however, that were the Argonaut Insurance Company to leave Pennsylvania tomorrow, 4,200 Pennsylvania doctors would be without insurance and would be unable to treat patients. Are there other insurance companies waiting in the wings to gobble up Argonaut policyholders? NO! Insurance for medical malpractice is an unwanted venture. Physicians get sued, and lose money for insurance companies. Not only in Pennsylvania, but in other states as well. Is it a one insurance company problem? No. Argonaut has played no role in nearby Maryland and yet Maryland has a crisis every bit as serious as ours. Physicians are an easy mark, a lush target, because the rules for the care of the sick are being written by the legal system, not by those knowledgeable in medicine. Gentlemen - when you have a heart attack, ask yourselves whether you would rather be treated by each other in consultation or by a physician.

At the same time the Pennsylvania Medical Society believes the Legislature has an obligation to hear testimony on all the relevant facts contributing to this problem. It believes that you will not accept as evidence hearsay about insurance companies and alleged profits from second and third hand sources. If such evidence is relevant, it should be sought directly from those involved and under oath. Nor should the Argonaut Insurance Company filing be held to a standard not required of filings by other companies writing similar insurance in Pennsylvania. If the department has inadequate malpractice actuarial statistics from the industry, insurance laws should be amended accordingly.

Let us move on to section 103 which reads in part ". . . It is the purpose of this act to make available patient's compensation insurance at a reasonable cost, and to establish a system through which a person who has sustained injury or death as a result of tort or breach of contract by a health care provider can obtain a prompt determination and adjudication of his claim and fair and reasonable compensation at a fair and reasonable cost."

We are in full and complete agreement with this statement of purpose and to that end you shall receive the complete support of the Pennsylvania Medical Society. The remainder of Bill 1367, however, fails to deal realistically with the root causes of the crisis and, therefore, is no solution. We should instead be discussing HB 805.

The Regional Arbitration Panels in section 308 (b) do not require a physician on the panel. The composition of panels should be modified to always include a physician in cases involving a doctor and to bring in other health providers as particular cases require. Assessment of medical judgment and/or performance solely by non-physicians is unworkable and unreasonable.

While arbitration is a concept which the Medical Society endorses, we find the true elements of arbitration missing from House Bill 1367. The panels as written are mandatory screening panels. The decision of the panel is not final and binding. In every instance, the case may be appealed to the courts. The term "Arbitration Panel" is a misnomer for a screening panel which merely adds another step to the already cumbersome and antiquated court system. If final decisions must still be made in the courts, cases will continue to be delayed for years.

Justice delayed is no justice at all. The Pennsylvania Medical Society supports a type of patient compensation board which is able to act promptly and reach a final and binding determination as called for by House Bill 805. The Pennsylvania Medical Society supports true arbitration, but not a screening panel system under the guise of arbitration.

Another fault in 1367 is lack of a definition of "fair and reasonable compensation at a fair and reasonable cost." The Pennsylvania Medi-

(Continued on page 79)

Board names Benjamin Rush Awards recipients

The Board of Trustees and Councilors have named the recipients of the State Benjamin Rush Awards for 1975.

Roger A. Congdon, of Ulster, will receive the individual award for his voluntary emergency medical activities which include helping to found an ambulance service in his area and training about 2000 persons in first aid methods.

The Susquehanna University Student Volunteer Program was named the recipient of the group award. The program involves students in a variety of community services such as working with children and the elderly, recycling projects, blood donation, and clothing collection.

The awards will be presented at the 1975 Annual Session in October.

CLYDE H. JACOBS, M.D., president of the Northumberland County Medical Society, presents the county Benjamin Rush Award to a member of the Susquehanna University Student Volunteer Program for a variety of volunteer activities carried out by the group. The student volunteer program also received the State Society Benjamin Rush Award which will be presented at the state dinner during the Annual Session of the House of Delegates.

PSRO session slated

The fifth annual General Session and House of Delegates meeting of the American Association of Foundations for Medical Care (AAFMC), combined with the annual Educational Session of the American Association of Professional Standards Review Organizations (AAPSRO), will be held August 9-13 at the Fairmont Hotel in San Francisco.

Included in the program for the General Session are discussions on National Health Insurance, the National Health Resources and Development Act, PSRO and FMC sponsored Health Care Delivery Systems, and FMCs as Individual Practice Associations (IPA). AAPSRO educational sessions have been designed as workshops for physicians, executive directors, review coordinators, and others working in the PSRO field. Experts in the fields of PSRO, HMO, IPA, FMC, fiscal intermediaries, and other nationai health-oriented organizations will conduct the various workshops and discussion groups during the five day sessions.

For information on registration and reservations, contact AAFMC, P.O. Box 230, Stockton, CA 95201; telephone (209) 948-4550.

Pittsburgh HMO opens

Penn Group Health Plan (PGHP) has opened its first ambulatory care center in Montefiore Hospital, Pittsburgh. The center provides members with a complete package of comprehensive health services including unlimited hospitalization, emergency care, skilled nursing care, medical visits, home health visits, diagnostic studies, mental health services, preventive dental care, and health care visits. Medical care is being provided by Penn Group Medical Associates under the medical direction of W. John Siar, M.D.

Eli S. Egert, president of PGHP, stated that the plan is submitting an application to qualify as an HMO under Public Law 93-222, the Federal HMO Act of 1973. A recent favorable evaluation by the Department of Health, Education, and Welfare makes the outlook hopeful. If the PGHP qualifies, they may then, among other things, be able to obtain low cost, long term financing to expand the program.

All patient information is kept in a single medical record. As more PGHP centers open, members' records can be quickly transmitted from one location to another through telephone linked facsimile equipment. A subscriber could then obtain service at any PGHP health care center.

Pennsylvania's medical schools graduate 961 in 1975 —

Jefferson Medical College

Jefferson Medical College, Thomas Jefferson University held its 151st commencement on June 6 at the Academy of Music in Philadelphia. This year 215 medical degrees were conferred bringing Jefferson's medical degree graduate total to 22,449. Of the three honorary degrees awarded, one went to Anthony F. DePalma, M.D., chairman of the department of orthopedic surgery at Martland Hospital, College of Medicine and Dentistry of New Jersey, who received a Doctor of Letters degree. Graduate degrees in medicine numbered 17, including 11 Ph.D.s. The College of Allied Health Sciences awarded 20 degrees in medical technology.

University of Pennsylvania

The University of Pennsylvania held general commencement exercises May 18 at Franklin Field. Medical degrees awarded numbered 175. President Gerald R. Ford delivered the commencement address and received an honorary degree from the university. On May 17, 1775 members of the Continental Congress, including George Washington, John Hancock, Samuel Adams, John Adams, John Jay, Thomas Mifflin, and Patrick Henry, attended the graduation exercises at the university.

Medical College of Pennsylvania

The Medical College of Pennsylvania held its commencement on May 24 in Irvine Auditorium. Elisabeth Kubler-Ross, M.D., psychiatrist, author, lecturer, and international authority on death and dying, delivered the graduation address entitled "Facing Our Finiteness—a Lesson for Living." Medical degrees conferred totaled 94—62 women and 32 men. One of the two graduate degrees in medicine awarded went to Susan V. McLeer, M.D., who received a Master of Science in psychiatry. Allied health science degrees numbered 32. Five honorary degrees were awarded. Elisabeth Kubler-Ross, M.D., Bernard Alpers, M.D., emeritus professor in neurology at Jefferson Medical College, and Gertrude Henle, M.D., professor of virology and pediatrics at the Children's Hospital of Philadelphia, received honorary Doctor of Science degrees.

University of Pittsburgh

Awarding of diplomas at the University of Pittsburgh took place May 29 at Carnegie Music Hall. Lewis Thomas, M.D., president of Sloan Kettering Institute for Cancer Research, was the graduation speaker. During the ceremony 117 medical degrees were conferred. Graduate degrees awarded were 4 Master of Science and 6 Doctor of Philosophy. The School of Health Related Professions conferred 122 Bachelor of Science degrees.

Hahnemann Medical College

The commencement exercises of Hahnemann Medical College were held June 5 at the Academy of Music in Philadelphia. The college awarded 124 medical degrees, 98 associate of science degrees, and 33 bachelor of science degrees. U.S. Representative Lloyd M. Bentsen, Jr., J.D., LL.D., delivered the commencement address and received one of the two honorary degrees awarded. Other degrees conferred were 35 Master of Science, 5 Doctor of Psychology, and 8 Doctor of Philosophy.

Hershey Medical Center

The Milton S. Hershey Medical Center of The Pennsylvania State University held its fifth commencement May 24 at Founders Hall of the Milton Hershey School. The Medical Center awarded 65 medical degrees and five graduate degrees. These bring the total

TWO SETS of identical twins were among the 215 graduates of Jefferson Medical College, Thomas Jefferson University. In the photo above are Carol (left) and Phyllis Morningstar, of Altoona, and Robert (left) and Richard Gordon, of Philadelphia. The Gordons have earned medical degrees only five years after high school graduation through an accelerated program in cooperation with the Pennsylvania State University. Both the Morningstars and Robert Gordon are planning residencies in family medicine while Richard plans to pursue internal medicine.

those entering in fall feted in State College

The Sixth Councilor District held its eighth annual dinner in honor of students from the Pennsylvania State University and Juniata College entering medical schools in the fall. Attending the dinner were, left to right, A. Reynolds Crane, M.D., Society President; H. Thompson Dale, M.D., former trustee of the Sixth District; Joseph M. Stowell, M.D., trustee of the Sixth District; and John Rogalski, Society assistant secretary. Dr. Stowell was master of ceremonies and Dr. Crane delivered the dinner speech.

number of graduates from Pennsylvania's newest medical school to 265. The speaker at the commencement was Dr. Wesley W. Posvar, Chancellor of the University of Pittsburgh. Of the graduating medical class, 50 percent are remaining in Pennsylvania. Primary care specialties were chosen by 75 percent, including 22 percent in family medicine.

Temple University

Commencement exercises of Temple University School of Medicine took place May 29 on Temple's Ambler Campus. A total of 171 medical degrees were conferred. In addition, graduate degrees in medicine numbered eight. William Rafsky, executive director of the Bicentennial Corporation and a member of the board of directors for Temple, was the commencement speaker.

Health meet scheduled

The State Health Conference Committee is sponsoring the 22nd Annual Pennsylvania Health Conference August 18-20 at the University of Pennsylvania Conference Center. The conference is entitled "Will Legislation and Planning Solve Our Health Problems?"

Highlights of the conference will include multiphasic screening, professional liability, environmental health, emergency medical services, quackery and frauds, home health care, careers in the health field, and new trends in health education.

Accomodations include one, two, and three bedroom suites in a twenty-five story residence tower. Meals will be provided by the university cafeteria in the Conference Center for a small fee. The conference has been approved for Category II credit toward the Physician's Recognition Award of the American Medical Association. For more information contact Ken Jones at Society Headquarters.

Rinehimer named to panel

Robert E. Rinehimer, president of Pennsylvania Blue Shield, Camp Hill, has been named to the Advisory Panel on National Health Insurance of the House Ways and Means Committee on Health.

The panel was formed by subcommittee chairman Dan Rostenkowski (D-Ill.) to assist in formulating National Health Insurance legislation, which he feels "is a must. . . . The people who have agreed to serve on this advisory panel are recognized experts on various issues which the subcommittee will have to resolve and should contribute much to our work."

Society endorses Pennsylvania Diet Manual

The Society Board of Trustees and Councilors and Council on Education and Science have endorsed a new diet manual, the Pennsylvania Diet Manual, as a successor to the Manual of Standard Therapeutic Diets originally prepared and distributed by PMS.

The manual was developed under state contract by the Institution Food Research and Services Program of Pennsylvania State University. A committee composed of representatives of various health care disciplines joined in the planning.

All diets included in the manual are applicable to physicians' use. The planning committee first developed a diet for the normal, healthy person and made modifications on it in accord with the best practices for diets to be used for therapeutic reasons. As a result the manual developes sequentially and is indexed accordingly. It has a looseleaf format in order that physicians may remove a complete diet and give a photocopy to patients.

The Pennsylvania Diet Manual may be purchased for $14.00 with the hard vinyl cover, or $7.50 for all inserts plus a soft cover after the purchase of a hard cover copy. Checks should be made payable to Pennsylvania Diet Manual. The manual may be obtained from the Institution Food Research and Services, Pennsylvania State University, Human Development Building, University Park, PA 16802.

Commission announces new accreditations

York Hospital's continuing education program has been fully accredited for a four year period by the Society's Commission on Accreditation. Among the hospital's activities are grand rounds, teaching rounds, seminars, workshops, scientific sessions of medical specialty societies, mini residencies, and a visiting lecturer program.

At the May 28 meeting of the Commission on Accreditation the Chester County Hospital, West Chester, was accredited for a two year period and St. Margaret's Memorial Hospital, Pittsburgh, for a four year period. Also accredited for two years was the Clinical School of the Family Institute of Philadelphia, a small post graduate program which teaches physicians and other health personnel how to counsel families who have mental health problems.

Pennsylvanians on USP

The United States Pharmacopeial Committee of Revision, responsible for preparing the next United States Pharmacopeia and National Formulary, was elected at the recent quinquennial meeting of the United States Pharmacopeia Convention, Inc. The revision committee will serve from 1975-80.

Among the newly elected committee members from the medical sciences is Donald Kaye, M.D., professor and chairman of the department of medicine at the Medical College of Pennsylvania. Members from Pennsylvania who are in the pharmaceutical and allied sciences are John V. Bergen, Ph.D., Gerald J. Papariello, Ph.D., and Murray M. Tuckerman, Ph.D., from Philadelphia, John L. Colaizzi, Ph.D., and Joseph A. Feldman, Ph.D., from Pittsburgh. The new committee will hold its organizational meeting June 11 in Washington, D.C., and will immediately begin revision projects.

The Nineteenth Revision of the Pharmacopeia (USP XIX) and the Fourteenth Edition of the National Formulary (NF XIV) were published in December 1974 and will become official July 1. Also to become official July 1 is a composite supplement comprising the First Supplement to USP XIX and NF XIV. The supplement is a composite listing since, pursuant to the purchase of the National Formulary by the U.S.P. Convention, Inc., in January, responsibility for all NF XIV supplements and future editions rests with the Pharmacopeial organization.

All holders of USP XIX and NF XIV who have returned the order form supplied with each copy will receive automatically a copy of the First Supplement. All holders of USP XIX will receive in addition a complimentary copy of the 1975 edition of the *USP Guide to Select Drugs,* published in April.

New health center open

The Evelyn G. Frederick Health Center began official operations in Millersburg July 1. The health center's temporary location is in the offices of Henry G. Hottenstein, M.D., a Millersburg physician for 40 years and instrumental in bringing together the Pennsylvania State University and the Evelyn G. Frederick Trust to establish the center.

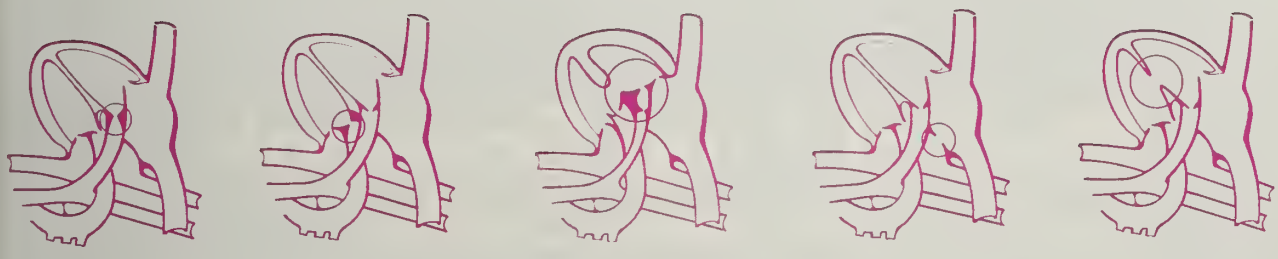
William D. Hakkarinen, M.D., former chief resident in family medicine at the Milton S. Hershey Medical Center, is medical director of the center and assistant professor of family and community medicine in the Penn State College of Medicine. Rodney K. Hough, M.D., is staff physician and instructor in family and community medicine.

cardiovascular brief

Scientific Sessions

of the American Heart Association, Pennsylvania Affiliate

September 12-13, 1975 Hershey Motor Lodge



Heart Failure and Heart Murmurs

PRESENTATIONS / WORKSHOPS

Congestive heart failure ... pulmonary edema "symptom" ... phonocardiography ... drug management ... rheumatic mitral valve disease ... mitral valve-Click syndrome ... aortic stenosis ... acute and chronic aortic regurgitation ... subacute bacterial endocarditis ... asymmetric septal hypertrophy ... valve replacement ... heart murmurs.

CREDITS

This continuing medical education activity is acceptable for 12 credit hours in Category 1 for the Physician's Recognition Award of the AMA and PMS; application has been made for credit from AAFP and ACGP in Osteopathic Medicine and Surgery.

FEE

Registration fee: $40 plus luncheons, if desired, at $6 each. Medical students, residents and interns are exempt from the registration fee.

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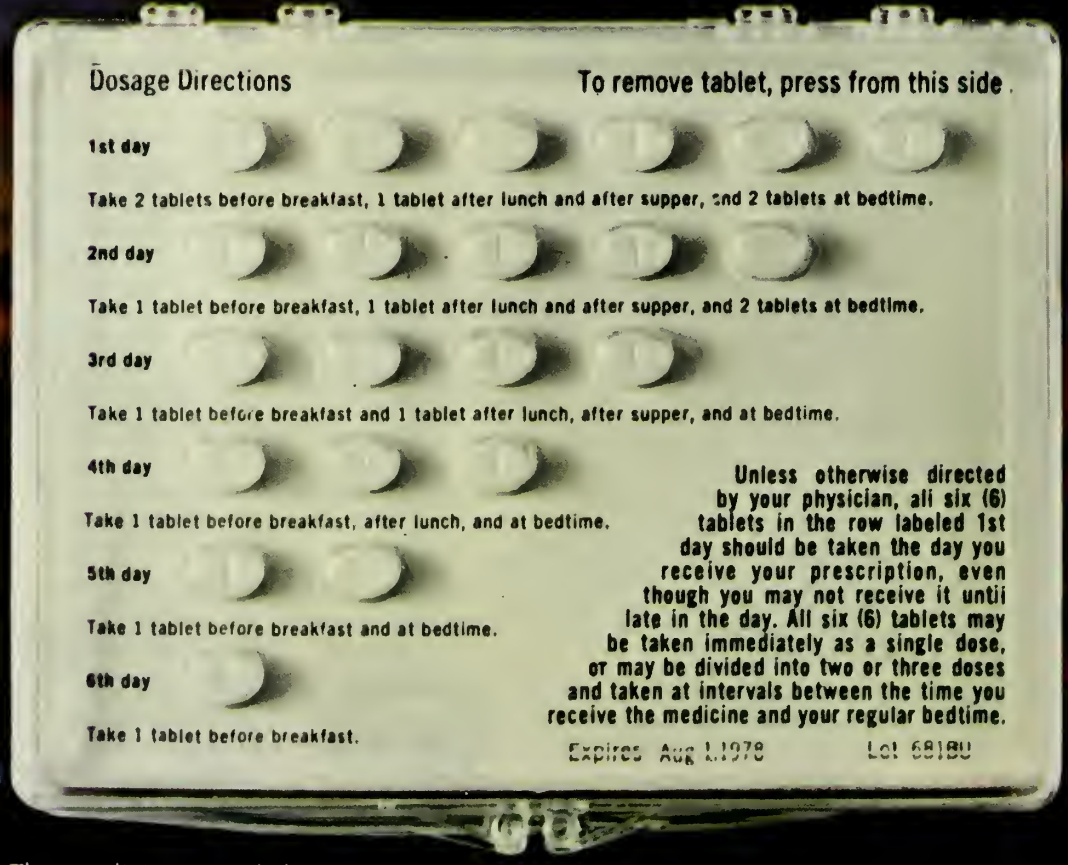
Dosage Directions
To remove tablet, press from this side.
1st day
Take 2 tablets before breakfast, 1 tablet after lunch and after supper, and 2 tablets at bedtime.
2nd day
Take 1 tablet before breakfast, 1 tablet after lunch and after supper, and 2 tablets at bedtime.
3rd day
Take 1 tablet before breakfast and 1 tablet after lunch, after supper, and at bedtime.
4th day
Take 1 tablet before breakfast, after lunch, and at bedtime.
5th day
Take 1 tablet before breakfast and at bedtime.
6th day
Take 1 tablet before breakfast.
Unless otherwise directed by your physician, all six (6) tablets in the row labeled 1st day should be taken the day you receive your prescription, even though you may not receive it until late in the day. All six (6) tablets may be taken immediately as a single dose, or may be divided into two or three doses and taken at intervals between the time you receive the medicine and your regular bedtime.
Expires Aug 1 1978
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The explicit printed dosage instructions that accompany each Dosepak make it easy for the patient to understand and follow the dosage regimen.

Poison ivy and other severe allergic states intractable to adequate trials of conventional treatment will often respond to a short, intensive, adjunctive course of Medrol. Medrol Dosepak is designed to provide a tapered, six-day course of methylprednisolone tablets.

On occasion, a six-day course of Medrol therapy may not be sufficient and therapy may need to be extended. If there is continued contact with the sensitizing agent, corticosteroids will not completely suppress the inflammatory response. A further caution: If lesions become infected during Medrol therapy, it should be remembered that steroids may decrease resistance to infection and hinder the body's ability to localize an infection.

MEDROL COMPRESSED TABLETS—2, 4 & 16 MG
(METHYLPREDNISOLONE TABLETS, N.F., UPJOHN)

DESCRIPTION AND ACTIONS: Medrol (methylprednisolone) is a synthetic glucocorticoid with potent anti-inflammatory effects. It is readily absorbed from the GI tract. Glucocorticoids cause profound and varied metabolic effects and modify the body's immune responses to diverse stimuli.

INDICATIONS: 1. **Endocrine Disorders:** Primary or secondary adrenocortical insufficiency (hydrocortisone or cortisone is the first choice; synthetic analogs may be used in conjunction with mineralocorticoids where applicable; in infancy, mineralocorticoid supplementation is of particular importance). Congenital adrenal hyperplasia; nonsuppurative thyroiditis; hypercalcemia associated with cancer. 2. **Rheumatic Disorders:** As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in: psoriatic arthritis; rheumatoid arthritis (selected cases may require low-dose maintenance therapy); ankylosing spondylitis; acute and subacute bursitis; acute nonspecific tenosynovitis; acute gouty arthritis. 3. **Collagen Diseases:** During an exacerbation or as maintenance therapy in selected cases of—Systemic lupus erythematosus; acute rheumatic carditis. 4. **Dermatologic Diseases:** Pemphigus; bullous dermatitis herpetiformis; severe erythema multiforme (Stevens-Johnson syndrome); exfoliative dermatitis; mycosis fungoides; severe psoriasis. 5. **Allergic States:** Control of severe or incapacitating allergic conditions intractable to adequate trials of conventional treatment: Seasonal or perennial allergic rhinitis; bronchial asthma; contact dermatitis; atopic dermatitis; serum sickness. 6. **Ophthalmic Diseases:** Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as—allergic corneal marginal ulcers; herpes zoster ophthalmicus; anterior segment inflammation; diffuse posterior uveitis and choroiditis; sympathetic ophthalmia; allergic conjunctivitis; keratitis; chorioretinitis; optic neuritis; iritis and iridocyclitis. 7. **Respiratory Diseases:** Symptomatic sarcoidosis; Loeffler's syndrome not manageable by other means; berylliosis; fulminating or disseminated pulmonary tuberculosis when concurrently accompanied by appropriate antituberculous chemotherapy. 8. **Hematologic Disorders:** Idiopathic and secondary thrombocytopenia in adults; acquired (autoimmune) hemolytic anemia; erythroblastopenia (RBC anemia); congenital (erythroid) hyperplastic anemia. 9. **Neoplastic Diseases:** For palliative management of: leukemias and lymphomas in adults; acute leukemia of childhood. 10. **Edematous States:** To induce a diuresis or remission of proteinuria in the nephrotic syndrome, without uremia, of the idiopathic type or that due to lupus erythematosus. 11. **Miscellaneous:** Tuberculous meningitis with subarachnoid block or impending block when concurrently accompanied by appropriate antituberculous chemotherapy. Systemic dermatomyositis (polymyositis).

CONTRAINDICATIONS: Systemic fungal infections.

WARNINGS: In patients on corticosteroid therapy subjected to unusual stress, increased dosage of rapidly acting corticosteroids before, during, and after the stressful situation is indicated.

Corticosteroids may mask some signs of infection and new infections may appear during their use. There may also be decreased resistance and inability to localize infection. Prolonged use may enhance the establishment of secondary ocular infections due to fungi or viruses.

Since adequate human reproductive studies have not been done, the use in pregnancy, nursing mothers or women of childbearing potential requires that the possible benefits be weighed against the potential hazards to the mother and the embryo or fetus. Infants should be observed for signs of hypoadrenalism.

Average and large doses of hydrocortisone or cortisone can cause elevation of blood pressure, salt and water retention, and increased excretion of potassium. These effects are less likely to occur with the synthetic derivatives except when used in large doses. Dietary salt restriction and potassium supplementation may be necessary. All corticosteroids increase calcium excretion.

While on corticosteroid therapy, patients should not be vaccinated against smallpox. Other immunization procedures should not be undertaken in patients who are on corticosteroids, especially on high dose, because of possible hazards of neurological complications and a lack of antibody response.

The use of corticosteroids in active tuberculosis should be restricted to those cases of fulminating or disseminated tuberculosis in which the corticosteroid is used for the management of the disease in conjunction with an appropriate antituberculous regimen.

If corticosteroids are indicated in patients with latent tuberculosis or tuberculin reactivity, close observation is necessary as reactivation of the disease may occur. During prolonged corticosteroid therapy, these patients should receive chemoprophylaxis.

PRECAUTIONS: Hormone therapy is an adjunct to, and not a replacement for, conventional therapy.

Dosage should be individualized according to the severity of the disease and the response of the patient. As soon as a satisfactory clinical response is obtained, the daily dose should be reduced, either to termination of treatment or to the minimal effective maintenance dose level. The lowest possible dose should be used and when reduction in dosage is possible, the reduction should be gradual if the drug has been administered for more than a few days. If a period of spontaneous remission occurs in a chronic condition, treatment should be discontinued.

Drug-induced secondary adrenocortical insufficiency may be minimized by gradual reduction of dosage. This type of relative insufficiency may persist for months after discontinuation of therapy; therefore, in any situation of stress occurring during that period, hormone therapy should be reinstituted. Since mineralocorticoid secretion may be impaired, salt and/or a mineralocorticoid should be administered concurrently.

There is an enhanced effect of corticosteroids on patients with hypothyroidism and in those with cirrhosis.

Corticosteroids should be used cautiously in patients with ocular herpes simplex because of possible corneal perforation.

Psychic derangements may appear or existing emotional instability or psychotic tendencies may be aggravated by corticosteroids.

Aspirin should be used cautiously in conjunction with corticosteroids in hypoprothrombinemia..

Steroids should be used with caution in nonspecific ulcerative colitis, if there is a probability of impending perforation, abscess or other pyogenic infection; diverticulitis; fresh intestinal anastomoses; active or latent peptic ulcer; renal insufficiency; hypertension; osteoporosis; and myasthenia gravis.

Growth and development of infants and children on prolonged corticosteroid therapy should be carefully observed.

Blood pressure, body weight, routine laboratory studies, including 2-hour postprandial blood glucose and serum potassium, and a chest X-ray should be obtained at regular intervals during prolonged therapy. Upper GI X-rays are desirable in patients with known or suspected peptic ulcer disease.

ADVERSE REACTIONS: Fluid and Electrolyte Disturbances. Sodium retention; fluid retention; congestive heart failure in susceptible patients; potassium loss; hypokalemic alkalosis; hypertension. **Musculoskeletal.** Muscle weakness; steroid myopathy; loss of muscle mass; osteoporosis; vertebral compression fractures; aseptic necrosis of femoral and humeral heads; pathologic fracture of long bones. **Gastrointestinal.** Peptic ulcer with possible perforation and hemorrhage; pancreatitis; abdominal distention; ulcerative esophagitis. **Dermatologic.** Impaired wound healing; thin fragile skin; petechiae and ecchymoses; facial erythema; increased sweating. May suppress reactions to skin tests. **Neurological.** Increased intracranial pressure with papilledema (pseudotumor cerebri) usually after treatment. Convulsions; vertigo; headache. **Endocrine.** Development of Cushingoid state; suppression of growth in children; secondary adrenocortical and pituitary unresponsiveness, particularly in times of stress, as in trauma, surgery or illness; menstrual irregularities; decreased carbohydrate tolerance; manifestations of latent diabetes mellitus; increased requirements for insulin or oral hypoglycemic agents in diabetics. **Ophthalmic.** Posterior subcapsular cataracts; increased intraocular pressure; glaucoma; exophthalmos. **Metabolic.** Negative nitrogen balance due to protein catabolism.

DOSAGE AND ADMINISTRATION: The initial dosage may vary from 4 to 48 mg per day. **Requirements are variable and must be individualized on the basis of the disease under treatment and the response of the patient.** The proper maintenance dosage should be determined by decreasing the initial dosage in small decrements at appropriate time intervals until the lowest dosage which will maintain an adequate clinical response is reached. If after long-term therapy the drug is to be stopped, it is recommended that it be withdrawn gradually rather than abruptly.

ALTERNATE-DAY THERAPY (ADT): ADT is a corticosteroid dosing regimen in which twice the usual daily dose of corticoid is administered every other morning. The purpose of this mode of therapy is to provide the patient requiring long-term pharmacologic dose treatment with the beneficial effects of corticoids while minimizing certain undesirable effects including pituitary-adrenal suppression, the Cushingoid state, corticoid withdrawal symptoms, and growth suppression in children.

Medrol (methylprednisolone) or other short-acting (producing adrenocortical suppression for 1¼ to 1½ days following a single dose) corticoids are recommended for ADT. Complete control of symptoms will not be possible in all patients. When considering this mode of therapy, keep in mind the basic principles and indications for corticosteroid therapy. The benefits of ADT should not encourage the indiscriminate use of steroids.

SUPPLIED: 2 mg—in bottles of 30 and 100 scored tablets; **4 mg**—in bottles of 30, 100 and 500 scored tablets and in 21 scored tablet Dosepak™ ; **16 mg**—in bottles of 50 scored tablets and in 14 scored tablet ADT Pak® (formerly Alternate Daypak®).

MED B-8-S (MAG)

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Louis Rukeyser
in Monte Carlo

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A Wall Street specialist in MONTE CARL(
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MDs in the news

Franklyn Clarke, M.D., director of Philadelphia State Hospital, recently testified before a Senate Committee on Public Health and Welfare about the care of the mentally ill. He stressed the need for institutional and community programs in mental health and was well received. Dr. Clarke also appeared in May on the "Morning-Side" program on WCAU-TV in Philadelphia. He discussed mental health issues. Also appearing was **Joseph Mendels, M.D.**, professor and chief of affective diseases in the department of psychiatry at the Hospital of the University of Pennsylvania. The appearance was arranged to coincide with Mental Health Month.

Raymond C. Grandon, M.D., member of the Society Board of Trustees, was recently re-elected president of the Pennsylvania Society of Internal Medicine at its 13th annual meeting in Philadelphia. Dr. Grandon is the first president to be elected to a second term in that organization.

James A. Collins, M.D., was recently re-elected to the board of trustees of the American Society of Internal Medicine at the organization's annual meeting in San Francisco. He first became a trustee in 1972 and heads the society's component societies council. Dr. Collins is director of the department of internal medicine at Geisinger Medical Center, Danville, clinical associate professor of medicine at Hershey Medical Center, and a member of the Board of Directors of Pennsylvania Blue Shield.

Lee B. Grant, M.D., Pittsburgh, was named recently to the board of directors of the American Occupational Medical Association. He is one of five physicians elected to a three year term on the board. Dr. Grant is medical director of PPG Industries and president of the American College of Preventive Medicine.

The Medical College of Pennsylvania has appointed **Margaret S. Mahler, M.D.**, world renowned child psychoanalyst, as a visiting professor in child psychoanalysis. Dr. Mahler introduced the Rorschach technique to Vienna in the late 1920s and is well known for her study of psychotic infants. She was the recipient of an honorary doctor of medical science from the Medical College in 1971. She is a member of the Philadelphia Psychoanalytic Institute and was chairman of its child analysis curriculum for 13 years.

DR. MAHLER

DR. KOWLESSAR

Muriel Kowlessar, M.D., Philadelphia, is the newly appointed director of Pediatric Group Services at the Medical College of Pennsylvania. The Pediatric Group Services offers children ranging from newborn to 17 years of age a wide variety of medical services. Dr. Kowlessar is an associate professor in the Medical College of Pennsylvania.

The 1975 officers of the Northumberland County Medical Society are the following: **Clyde H. Jacobs, M.D.**, Sunbury, president; **Benjamin M. Broscius, M.D.**, Shamokin, president elect; **Joseph M. Sienkiewicz, M.D.**, Mount Carmel, vice president; **G. R. Wentzel, M.D.**, Sunbury, secretary; and **W. W. Christman, M.D.**, Sunbury, treasurer.

Gerhard Werner, M.D., has been named dean of the University of Pittsburgh School of Medicine. He has been serving as acting dean, succeeding **Donald N. Medearis, M.D.**, who resigned a year ago.

Russell B. Roth, M.D., Erie, was awarded the Behrend College Medallion recently. The award is the highest form of recognition by the college and is presented to area residents who have brought recognition to the area through excellence in their specialized fields.

Eugene Van Scott, M.D., recently received the 1975 Stephen Rothman Award of the Society of Investigative Dermatology. The award was given for his work with mycosis fungoides and treatment of it with a liquid form of nitrogen mustard, a derivative of the World War I mustard gas. Dr. Van Scott is a professor of dermatology at Temple University School of Medicine.

Doris Gorka Bartuska, M.D., was recently named an Outstanding Educator of America. She is associate dean, associate professor of medicine, and director of the division of endocrinology and metabolism at the Medical College of Pennsylvania.

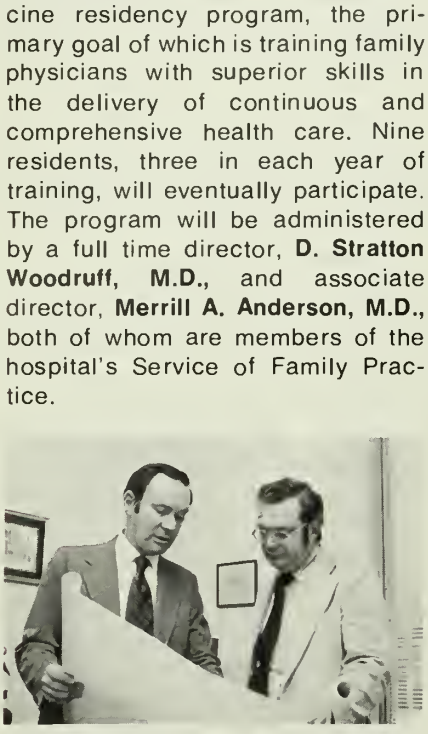
The Lehighton Area Chamber of Commerce recently presented its "Outstanding Citizen Award" to **Sylvester E. Lentz, M.D.** Dr. Lentz has practiced medicine in Lehighton since 1932 and has been there longer than any other physician.

James J. Houser, M.D., Franklin, was recently inducted as a fellow of the American College of Physicians at its recent meeting in San Francisco. Dr. Houser is also a diplomate of the National Board of Medical Examiners and the American Board of Internal Medicine.

J. D. McCallum, M.D., was recently honored with a testimonial dinner held by the Lions Club of Canton for his 48 years of service to the community. Included in the program was a testimonial from the Bradford County Medical Society.

MDs in the news

The Bryn Mawr Hospital inaugurated in early May a family medicine residency program, the primary goal of which is training family physicians with superior skills in the delivery of continuous and comprehensive health care. Nine residents, three in each year of training, will eventually participate. The program will be administered by a full time director, **D. Stratton Woodruff, M.D.,** and associate director, **Merrill A. Anderson, M.D.,** both of whom are members of the hospital's Service of Family Practice.



DRS. WOODRUFF AND ANDERSON

Frank B. Mahon, Jr., M.D., Sayre, was recently certified by the American Board of Urology. He is a member of the candidate group of the American College of Surgeons.

Francis W. Davison, M.D., received the Newcomb Award of the American Laryngological Association at the organization's annual scientific meeting held recently in Atlanta. The award was presented to him for his outstanding contributions to literature in the specialties of laryngolgy and rhinology. Dr. Davison is director of otolaryngology, emeritus, at Geisinger Medical Center, Danville.

Madhu Kalia, M.D., Hahnemann Medical College and Hospital, recently received a National Institute of Health, Research Career Development Award. The NIH grant is awarded to researchers whose work shows promise and who the institute believes will make a significant contribution to modern science. Dr. Kalia is associate professor in the department of physiology and biophysics. His research focuses on the central pathways of the pulmonary reflexes.

Robert I. Wise, M.D., Ph.D., Magee Professor of Medicine and chairman of the department at Jefferson Medical College, Thomas Jefferson University, retired recently. Friends and colleagues donated his portrait to the university on the occasion of Dr. Wise's retirement. He has been Magee Professor of Medicine and the department chairman since 1959.

The American College of Utilization Review Physicians, Inc., held its second annual business meeting recently in Hershey. Officers elected were: **Richard E. Gibbons, M.D.,** Philadelphia, president; **George W. Weber, M.D.,** Harrisburg, president elect; **Harold M. Cohen, M.D.,** Pittsburgh, first vice president; and **Richard B. Tobias, M.D.,** Williamsport, second vice president. **Robert Barto, M.D.,** Camp Hill, serves as chairman of the board.

John D. Hanlon, M.D., was installed recently as president of the Pennsylvania Academy of Family Physicians at the organization's annual dinner which was part of the 27th Annual Scientific Assembly and Convention.

G. Betty Kilpatrick, M.D., Beaver Falls, was recently awarded the Life "G," the highest honor conferred by the Geneva Alumni Association. The award is given every year to a Geneva graduate for achievement of service above self and noteworthy efforts on behalf of Geneva and the nation. Dr. Kilpatrick is a member of the county and State Societies, International Women's Medical Organization, and the Pennsylvania Medical Political Action Committee.

Luther W. Brady, M.D., professor and chairman of the department of radiation therapy and nuclear medicine, Hahnemann Medical College and Hospital, was recently appointed Hylda Cohn/American Cancer Society Professor of Clinical Oncology. He is the first Delaware Valley physician to be so named. The professorship carries with it a grant of $125,000. It was established to benefit the patient by placing more emphasis on cancer teaching in the medical schools and encouraging various hospital medical and scientific disciplines to use a team approach in treating the cancer patient.

Dr. Brady was also elected recently to a six year term as a trustee of the American Board of Radiology. He was nominated from the American Society of Therapeutic Radiologists. In addition, he was elected to a three year term on the Board of Chancellors of the American College of Radiology and to the chairmanship of the college's commission of radiation therapy.

The Lancaster City and County Medical Society's Distinguished Service Award was given to **Joseph A. Knepper, M.D.,** Leola, for his efforts in organizing the county's emergency ambulance services. The award was made at the society's annual banquet. Also honored were **Meade D. Schaffner, M.D.,** Lancaster, and **Samuel W. McNeal, M.D.,** Columbia, for 50 years in medical practice.

Leon L. Berns, M.D., was recently promoted to clinical professor of anatomy at Jefferson Medical College, Thomas Jefferson University.

H. Samuel Callen, M.D., was recently honored by the Lebanon County Medical Society for 50 years of service to the medical profession.

Your man in Lemoyne

Cyrus B. Slease, M.D. - Ninth District

MARY L. UEHLEIN
Managing Editor

Cyrus B. Slease, M.D., the quiet, gentle chairman of the Board of Trustees, has served as trustee and councilor for the Ninth District since 1963 and is completing his second full term this year. He has served as chairman of the Board since October 1973.

In representing physicians of the counties of Armstrong, Butler, Clarion, Indiana, Jefferson, and

Venango, Dr. Slease has concerned himself with the problems of rural and small town physicians. He has expressed the opinion that "Fee for service, whether privately paid or paid by a third party, should be based on the services rendered rather than on a profile which is only a partial picture of the fee pattern of an area, and in many cases is inaccurate, unjust, or both. Many years ago there was a justifiable reason for a difference in fees between rural and urban areas because of a difference in overhead cost. In this modern day the rural practitioner has to pay the same for car, gasoline, medicine and supplies, children's education, food, and clothing."

Dr. Slease sees a direct tie between the fee differential and the shortage of physicians in rural areas. He says, "In most cases the physician will pick the area where higher prevailing fees exist, everything else being equal."

Born in Armstrong County, Dr. Slease was educated and has spent all of his professional life in Pennsylvania, except for the period he served during World War II. He served with the U.S. Air Force as a lieutenant colonel from December 1942 until April 1946 in Florida, California, Texas, and Italy.

The 1937 Jefferson Medical College graduate did his premedical studies at Thiel College and interned at West Penn Hospital in Pittsburgh. He opened his general practice in Elderton and became active in county and State Society activities. Dr. Slease served as president and secretary of the Armstrong County Medical Society, and as a delegate to the State Society's House of Delegates prior to his election as trustee. He also has served the State Society as a member of the Council on Public Service (now the Council on Professional Relations and Services) and the Commission on Rural Health.

Dr. Slease is also an associate member of the International College of Surgeons. His civic activities include an interest in the local chapter of the American Lung Association and membership on the Municipal School Authority. He is on the staff of the Armstrong County Memorial Hospital.

Dr. Slease has served as chairman of the Board through the difficult malpractice crisis facing the medical profession and the public. In that role during the past eight months he has set something of a record for chairing meetings of the Board and its Executive Committee because of special meetings,

some using the telephone conference technique to save the valuable time of busy practitioners who provide the Society's leadership. His calm and reasoned approach as chairman has been seen as a great asset to the Board during very difficult discussions.

He leaves his post as trustee and councilor and as chairman of the Board at the end of the 1975 Annual Session of the House of Delegates.

Your man in Lemoyne

David W. Clare, M.D. - Tenth District

MARY L. UEHLEIN
Managing Editor

Even before the malpractice climate in Pennsylvania became stormy, David W. Clare, M.D., trustee and councilor for the Society's Tenth District, had become deeply concerned about the effect on patients of Pennsylvania's doctrine of informed consent.

Dr. Clare, a Pittsburgh surgeon, was elected trustee at the 1974 Session of the Society's House of Delegates to fill the unexpired term of William J. Kelly, M.D., who was elected vice president.

Shortly thereafter, while still serving as president of the Allegheny County Medical Society, he participated in a symposium on informed consent sponsored by the society. After hearing attorneys describe a complete explanation of therapy including all possible risks no matter how remote,

he commented: "No doctor should have to practice medicine in such a cruel way.

"Telling a patient he has cancer isn't easy, but telling him he could bleed or have peritonitis or a heart attack or pulmonary embolus if we go ahead with the only reasonable treatment is nearly always unasked for, unwanted, and terrifying information. I value the relationship I have with my patients and I for one don't intend to do this."

Dr. Clare's concern for his patients and the malpractice crisis which emerged shortly after he spoke those words have absorbed much of his time since he became trustee and councilor for the counties of Allegheny, Beaver, Lawrence, and Westmoreland, as the Board has become deeply involved in activating both physicians and the general public in the effort to bring about a solution.

A native of Apollo, Pennsylvania, Dr. Clare received his undergraduate degree from Thiel College and his M.D. from Temple University School of Medicine. He interned and did his surgical residency at University of Pittsburgh Medical Center Hospitals, but the time was broken by a two year period in the Army Air Force in which he served as a captain during World War II. He served as chief resident in general surgery at Presbyterian Hospital in 1950 and is board certified in surgery. He holds appointments to the staffs of Presbyterian University Hospital, Shadyside Hospital, Magee Womens Hospital, and Children's Hospital.

Dr. Clare has served both the State Society and the county society in a number of capacities and currently is a member of the Publication Committee of the Board and representative to the Council on Governmental Relations. He is a member and strong supporter of the AMA, and holds membership in the American College of Surgeons, the American Association for the Surgery of Trauma, the Pittsburgh Academy of Medicine, and Pittsburgh Surgical Society.

During his term as president of the Allegheny County Medical Society, Dr. Clare led a successful membership recruitment campaign during which he authored a two-part series of articles, "Getting Our Money's Worth," for the *ACMS Bulletin*. The articles outlined both the tangible and intangible benefits of membership in all three levels of organized medicine.

While serving as county society president, Dr. Clare led the membership in a unique helping hand undertaking. The Pittsburgh medical community joined other groups in providing supplies for hurricane torn Honduras. Included in the medical supplies donated by county society members were fully equipped medical bags, medications, and medical equipment, even an x-ray machine.

Dr. Clare spent a week-end in Honduras last fall immediately following the disaster. He accompanied the supplies from Pittsburgh and worked among the victims to combat possible epidemics. *La pistola de paz* was his weapon—the main ammunition was influenza and typhoid vaccines. His account of the experience in the *ACMS Bulletin*, December 28, 1974, makes fascinating reading and exhibits this trustee's deep concern for his fellow man.

His other deep concern is for his profession. Because of this, he feels that unity is essential. "Certainly differences of opinion are healthy, and deserve discussion and debate," he says, "but on those many issues on which we (physicians) agree—and they far outnumber our differences—unity is essential. Single voices in the halls of government go unheard; 200,000 voices magnified through the channels of organized medicine can assure us of input, perhaps even clout, in those areas which affect us as individual practitioners, our profession as a whole, and the patients we treat."

Specialty societies hold annual meetings

State radiologists meet

The 60th Annual Meeting of the Pennsylvania Radiological Society was held recently at the Host Corral in Lancaster.

Each year the society honors one of its members who has contributed to the practice of radiology and the society over the years. This year the society chose Marlyn W. Miller, M.D., now retired from private practice in Altoona. An oration in honor of Dr. Miller was delivered by John A. Kirkpatrick, Jr., M.D., professor of radiology at the Harvard Medical School and radiologist in chief at Children's Hospital Medical Center in Boston. Dr. Kirkpatrick's address was entitled "Common, Uncommon, and Confusing Lesions of the Growing Skeleton."

Officers elected were: Theodore A. Tristan, M.D., Harrisburg, president; Ross H. Smith, Jr., M.D., president elect; Robert B. Funch, M.D., first vice president, who will assume the presidency in 1977; Joseph A. Marasco, Jr., M.D., Pittsburgh, secretary; and Bernard J. Ostrum, M.D., treasurer.

The program, under the supervision of Robert E. Campbell, M.D., the society's editor, was acceptable for nine credit hours in Category I for the AMA Physician's Recognition Award.

Allergists elect officers

The Philadelphia Allergy Society held its annual spring meeting recently. Among the activities was the election of officers for the coming year. George A. Moll, M.D., was elected president, Samuel S. Burden, M.D., vice president, and Charles G. Blumstein, M.D., secretary treasurer. All the officers have their offices in Jenkintown.

Officers of the Pennsylvania Radiological Society

Anesthesiologists meet

The Pennsylvania Society of Anesthesiologists held its 1975 annual meeting entitled "PANESTHESIA 75" recently at the Penn Harris Motor Inn in Camp Hill.

Among the activities was the election of officers. John C. Cwik, M.D., Johnstown, succeeded Herbert C. Dodge, M.D., Meadowbrook, as president. Allen E. Yeakel, M.D., Hershey, was re-elected secretary and J. Donald Wentzler, M.D., Montoursville, continued as treasurer.

Included in the program were lectures and discussions presented by notable anesthesiologists from the state and across the nation. Discussions touched on many facets of anesthesiology health care. The three day program was approved for nine Category I credits toward the Physician's Recognition Award for the American Medical Association.

PAOO installs leaders

Louis E. Silcox, M.D., Philadelphia, was installed as president of the Pennsylvania Academy of Ophthalmology and Otolaryngology at the organization's 31st annual convention and scientific meeting. Dr. Silcox is chief of staff in otolaryngology at Lankenau Hospital and is on the surgical staff of the Hospital of the University of Pennsylvania.

Paul A. Cox, M.D., Carlisle, became president elect and will take over the presidency in 1976. Dr. Cox is past president of the Cumberland County Medical Society and the Reading Eye, Ear, Nose and Throat Society, and a member of the PMS Council on Governmental Relations.

Other officers elected were: Clyde B. Lamp, Jr., M.D., first vice president; William D. Angle, M.D., Williamsport, second vice president; Eugene B. Rex, M.D., Philadelphia, third vice president; Donald B. Kamerer, M.D., Pittsburgh, secretary; and Albert F. Cleveland, M.D., Drexel Hill, treasurer. Max Lee Ronis, M.D., Philadelphia, William C. Frayer, M.D., Philadelphia, and George J. Gerneth, M.D., Pittsburgh, were elected directors.

Among the activities of the convention was an awards ceremony. John T. Dickinson, M.D., received the Distinguished Service Award for his extensive work in the field of otolaryngology. He has become internationally known for his contributions to facial plastic and reconstructive surgery.

editorials

Support Benjamin Rush house restoration

With the approach of our country's 200th anniversary and concomitant Bicentennial Celebration, the Pennsylvania Medical Society has chosen as its project the restoration of the Benjamin Rush House which will be located in a new state park on the grounds of Philadelphia State Hospital. Contributions are being solicited from members to fulfill this aim. A total of $150,000 is needed to relocate and restore the house.

Reasons for this particular endeavor are many. Benjamin Rush, a native Pennsylvanian, was one of the most distinguished physicians and citizens of his time. In an era when colonial physicians were not accepted on an equal status with their European counterparts, Rush was one American who enjoyed a wide reputation in Europe. Whether this can be attributed to his schooling and degree from Edinburgh in 1768 or his adherence to Thomas Sydenham's theories on blood-letting or his voluminous writings or a combination of all three remains a puzzling and intriguing question. His contributions to medicine are numerous, among them, the treatment of yellow fever during the epidemics in Philadelphia in 1793 and 1797, and his studies on insanity. His monograph entitled *Medical Inquiries and Observations upon Diseases of the Mind* was the first American textbook of psychiatry. Based on his work with mental patients at the Pennsylvania Hospital, this book represents the culmination of observations made over a thirty year period. Interesting also is Rush's contribution to medicine of the word "tranquilizer," a name he applied to a restraining chair which he designed for mental patients.

A contemporary of John Adams, Thomas Paine, Benjamin Franklin, and George Washington, Rush exhibited a social and political awareness far beyond the scope of his time. Many of the things which he advocated were not to come about in his lifetime. A delegate to the Continental Congress and the only doctor of medicine to sign the Declaration of Independence, he desired American freedom from English monarchy. He served in the Continental Army under George Washington as surgeon-general, but due to political intrigue soon returned to his practice in Philadelphia. When the Treaty of Paris was concluded in 1783, Rush expressed the fear that the revolution might not end with the treaty and that, if carried to its fullest manifestation, would lead to anarchy. He was a proponent of the three branch government, executive, legislative and judicial, and deplored the unicameral legislature of Pennsylvania calling it, in a letter to his good friend John Adams, an exercise in mobocracy. He actively opposed the "Peculiar Institution" of slavery long before abolition became a celebrated cause, thereby arousing the emnity of the colonial slaveholders. He wrote against war, capital punishment, and intemperance.

An ardent patriot, a world renowned physician, and a social conscience of his time, Benjamin Rush deserves our recognition on this country's 200th birthday.

David A. Smith, M.D.
Medical Editor

I have to take Helen to a flower club luncheon at noon . . . have me paged at 12:15 . . .

in my opinion

Benevolent Selfishness

The village of Deadwood Landing was seriously affected by the sudden death of old Dr. Grubb. For as many years as most people could remember, Dr. Grubb had always been there ready to answer any call or take care of whatever difficulty might arise. After his passing, his shortcomings were rapidly forgotten and his name was almost sanctified.

There was a feeling of tremendous relief when, about a year later, the news began to spread around that a new doctor, Dr. Gordon Mild, would soon be filling old Dr. Grubb's place. And sure enough, Dr. Mild arrived, pink-faced, fresh from training with a pretty little wife and a plump little baby, to become the Deadwood Landing doctor. Dr. Mild was very conscientious and very eager to please his new patients. He had a lot of debts that had accumulated during his education, and he was fully devoted to succeeding both medically and financially. He had nothing else to do so he saw patients at any time of the day or night. His office, which was in the same building as his home, was open to all, night and day, seven days a week, and he willingly hopped into his little Volkswagen and made house calls through a radius of many miles from his office.

The people of Deadwood Landing were extremely pleased with the new doctor. They frequently commented in street-corner conversations that the good old-fashioned doctors were not dead and that Dr. Mild could hold his head up with any of the older generation. They were not unkind to Dr. Mild and his family. They paid their bills and they took pleasure in his growing success as he went from the Volkswagen to an Oldsmobile and when Mrs. Mild had her second baby, moved into a larger house. They were just a little bit put out when Dr. Mild announced that the office would not be open any more on Sundays or on Wednesday afternoons, but he was still available for emergencies and so they forgave him. When little Mary Mild had her second birthday, Dr. Mild got a Cadillac and kept the Oldsmobile for his wife. Financially he was doing very well and they rented a house for a month at the lake. The children enjoyed it very much, but Dr. Mild only got there two separate times for a day a piece. His success was a subject of discussion among his patients. "Moneybags" Mild they sometimes called him behind his back.

It came as a real shock to everybody in Deadwood Landing when he suddenly announced that he was leaving the little village to return to his medical school and prepare for the specialty of radiology. Most of his patients shook their heads and simply couldn't understand why he would want to leave a goldmine like this, but privately he told some of his better friends that Betty Mild had given him an ultimatum that she and the children, who scarcely knew their father, were going to leave him if he did not extricate himself from his overwhelming practice. He also felt that he had done more than his part working from 6:30 in the morning until 11:00 at night six days a week and frequently spending most of Sunday with his patients as well.

Dr. Mild left Deadwood Landing and all the most determined efforts of the citizens have failed to find another doctor to take his place. The good burghers shake their heads and somehow feel that something Dr. Mild did must have betrayed them.

Actually it is true that something that he did was responsible for his seeming betrayal of the community that made him so welcome. By not making an effort to make his life a livable one on a long term basis, Dr. Mild made certain that the time would come when he would have to pull up stakes and leave Deadwood Landing. Dr. Mild had a benevolent approach to his patients. There is no question about that. But when he made a life for himself built around his medical practice with the principal aim to make all the money he possibly could, he denied his children, denied his wife, and in the final analysis he denied himself. As a result he made sure that he would finally lose his family completely and eventually his mind itself, or he would have to go elsewhere and find another way of life.

The woman who called him at 11:30 at night to travel ten miles to vaccinate her child who had to go to school the next day may have been impressed with a real luxury level of physician service. Eventually there was one final night call, or one broken up meal too many, and the Mild family decided that they had a life to live and it was simply not possible to live it under the conditions in Deadwood Landing.

Only about forty miles from Deadwood Landing is the community of English Flats. It has a similar population and the people are not very different. They too lost an old doctor not too long ago and after a hiatus, a new physician, Harold Hard, came to their community. Like Dr. Mild, he was married but he had two little girls. His financial status was

not robust and he was anxious to make a good living.

Unlike Dr. Mild, however, Dr. Hard had an eye to the future. He was concerned with the suffering in his community but on a long term basis, because Dr. Hard felt that English Flats was a place where he wanted to live and raise his family and he wanted to make a satisfactory life there.

Dr. Hard began by putting an advertisement in the paper which included his office hours. They were listed at regular times and specifically included no evening hours, no hours Saturday afternoon or Sunday and no hours on Wednesdays at all. The ad also indicated that all consultations would be by prior appointment except in emergencies. The people of English Flats were a little bit taken aback by this arrangement since they had been accustomed to a "come whenever you feel the urge" arrangement with their old doctor. They also thought it was rather strange since Dr. Hard was frequently not very busy at first, but he stuck by his guns and before long it really paid off. His office appointments were full every time he made himself available.

Sometimes he even made himself a little bit objectionable when they tried to see him for non-emergency matters late at night or on his days off. But as time went by they learned to accept this too. Not only did they learn to accept his days off and his office hours by appointment, but they found that they also had to accept the fact that he left town to take vacations with his family, and also, occasionally for medical meetings and refresher courses. There was grumbling about this kind of thing for some time, but Dr. Hard proved himself to be capable and concerned and fair with his patients. When they remembered that his predecessor had had a little bit of a problem with a whiskey bottle that frequently made him less than fully efficient, they learned to accept the new procedure.

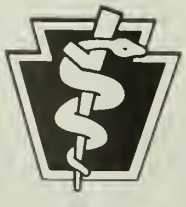
Over the years the Hard family proved themselves to be a very important part of community life in English Flats. Their relationship with the town was very congenial.

Two years after Dr. Mild left Deadwood Landing, the Methodist minister there was transferred to the church at English Flats. He had been about as close to Dr. Mild as anyone in the former community and he and Dr. Hard also became close friends. They sometimes discussed the medical problem of the previous community. Dr. Hard freely admitted that one thing that made his life in English Flats enjoyable was the fullness of his family life and the fact that he did have time for his wife and children. His practice did not become oppressive to him so that even after several years he looked forward to meeting almost every patient. Mr. Cloud, the minister, gave the problem a lot of thought. Finally in one of their conversations, he said to Dr. Hard, "You know Harold, Gordon Mild tried to give himself to his patients too much. He was so benevolent that finally he used up all the goodness that was in him and with no more to give, he had to leave that community.

"Because you started out with what seemed to some people to be a selfish attitude, you have made a place of contentment here in English Flats and the effect on the people has certainly been a benevolent one. Your success here was a result of benevolent selfishness."

George A. Rowland, M.D.
Guest Editor
Millville

QUESTIONS? SUGGESTIONS!
are invited for consideration by
The Committee on Objectives
Pennsylvania Medical Society



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Roche Laboratories has received several reports concerning the possibility of confusion between written prescriptions for Larocin (amoxicillin) and Lanoxin, a brand of digoxin from Burroughs Wellcome Co. While the potential for dispensing errors appears to be quite low, we have, nevertheless, decided to change the name of our product to LAROTID™ (amoxicillin).

Please be assured that the safety and effectiveness of the product itself are not in question. For this reason, pharmacists may continue to dispense Larocin until inventories are exhausted. As soon as possible, all packaging leaving Roche distribution centers will carry the new name, LAROTID.

We know you will agree that this action is in the best interest of your patients. If you have any questions about the name change, contact us directly at (201) 235-2357, or through your Roche representative. Before prescribing LAROTID, please consult the complete product information, a summary of which appears at the right.

ROCHE

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Infections due to susceptible strains of the following gram-negative organisms: *H. influenzae, E. coli, P. mirabilis* and *N. gonorrhoeae;* and gram-positive organisms: streptococci (including *Streptococcus faecalis*), *D. pneumoniae* and non-penicillinase-producing staphylococci. Therapy may be instituted prior to obtaining results from bacteriological and susceptibility studies to determine causative organisms and susceptibility to amoxicillin.

Contraindications: In individuals with history of allergic reaction to penicillins.

WARNINGS: SERIOUS AND OCCASIONALLY FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS REPORTED IN PATIENTS ON PENICILLIN THERAPY. ALTHOUGH MORE FREQUENT FOLLOWING PARENTERAL THERAPY, ANAPHYLAXIS HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. MORE LIKELY IN INDIVIDUALS WITH HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. BEFORE THERAPY, INQUIRE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS OR OTHER ALLERGENS. IF ALLERGIC REACTION OCCURS, INSTITUTE APPROPRIATE THERAPY AND CONSIDER DISCONTINUANCE OF AMOXICILLIN. **SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. ADMINISTER OXYGEN, INTRAVENOUS STEROIDS AND AIRWAY MANAGEMENT, INCLUDING INTUBATION, AS INDICATED.**

Usage in Pregnancy: Safety in pregnancy not established.

Precautions: As with any potent drug, assess renal, hepatic and hematopoietic function periodically during prolonged therapy. Keep in mind possibility of superinfections with mycotic or bacterial pathogens; if they occur, discontinue drug and/or institute appropriate therapy.

Adverse Reactions: As with other penicillins, untoward reactions will likely be essentially limited to sensitivity phenomena and more likely occur in individuals previously demonstrating penicillin hypersensitivity and those with history of allergy, asthma, hay fever or urticaria. Adverse reactions reported as associated with use of penicillins: *Gastrointestinal:* Nausea, vomiting, diarrhea. *Hypersensitivity Reactions:* Erythematous maculopapular rashes, urticaria. *NOTE:* Urticaria, other skin rashes and serum sickness-like reactions may be controlled with antihistamines and, if necessary, systemic corticosteroids. Discontinue amoxicillin unless condition is believed to be life-threatening and amenable only to amoxicillin therapy. *Liver:* Moderate rise in SGOT noted, but significance unknown. *Hemic and Lymphatic Systems:* Anemia, thrombocytopenia, thrombocytopenic purpura, eosinophilia, leukopenia, agranulocytosis. All are usually reversible on discontinuation of therapy and believed to be hypersensitivity phenomena.

Dosage: *Ear, nose, throat, genitourinary tract, skin and soft tissue infections*—Adults: 250 mg every 8 hours. Children: 20 mg/kg/day in divided doses every 8 hours; under 6 kg, 0.5 ml of Pediatric Drops every 8 hours; 6-8 kg, 1 ml of Pediatric Drops every 8 hours. *Lower respiratory tract infections and severe infections or those caused by less susceptible organisms*—Adults: 500 mg every 8 hours. Children: 40 mg/kg/day in divided doses every 8 hours; under 6 kg, 1 ml of Pediatric Drops every 8 hours; 6-8 kg, 2 ml of Pediatric Drops every 8 hours. *Gonorrhea* (acute uncomplicated anogenital and urethral infections)—Males and females: 3 grams as a single oral dose. *NOTE:* Children weighing more than 8 kg should receive appropriate dose of oral suspension 125 mg or 250 mg/5 ml. Children weighing 20 kg or more should be dosed according to adult recommendations.

Note: In gonorrhea with suspected lesion of syphilis, perform dark-field examinations before amoxicillin therapy and monthly serological tests for at least four months. In chronic urinary tract infections, frequent bacteriological and clinical appraisals are necessary. Smaller than recommended doses should not be used. In stubborn infections, several weeks' therapy may be required. Except for gonorrhea, continue treatment for a minimum of 48-72 hours after patient is asymptomatic or bacterial eradication is evidenced. Treat hemolytic streptococcal infections for at least 10 days to prevent acute rheumatic fever or glomerulonephritis.

Supplied: Amoxicillin as the trihydrate: Capsules, 250 mg and 500 mg; oral suspension, 125 mg/5 ml and 250 mg/5 ml; pediatric drops, 50 mg/ml.

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Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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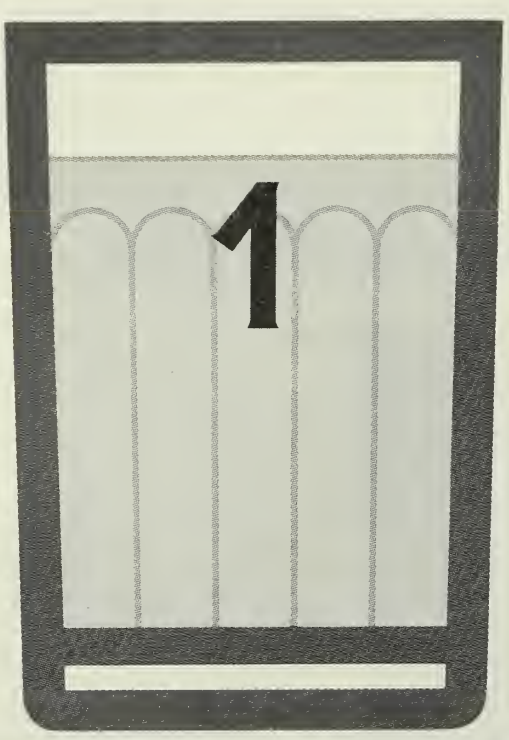

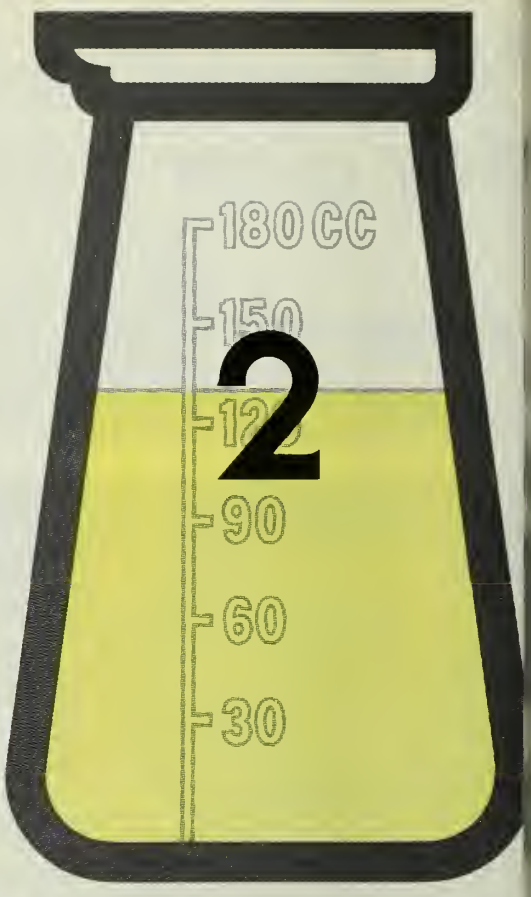

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ystitis

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic non-obstructed urinary tract infections (primarily pyelonephritis, pyelitis, and cystitis) due to susceptible organisms. ***Note:* Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials, including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

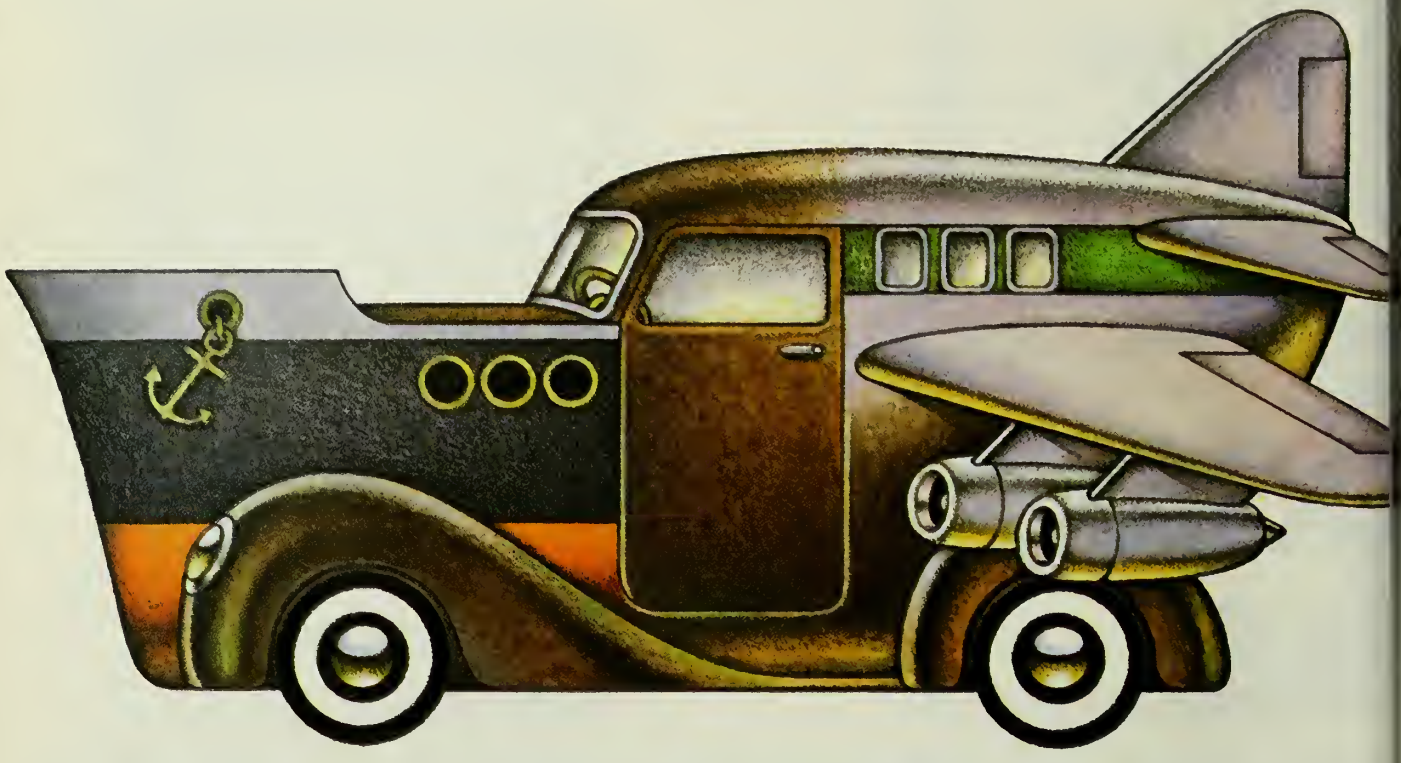
Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

- **Effective against susceptible E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis and, less frequently, Proteus vulgaris**



On land, sea, and in the air...

Up to 24 hours of effective control with a single dose...in nausea, vomiting and dizziness associated with motion sickness.

Dosage: 25 to 50 mg. 1 hour before travel.

Available on prescription only.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25 Chewable Tablets
(meclizine HCl) 25 mg.

for motion sickness

Maalox®...
on balance, it's better

- **more effective**—49% more acid neutralizing capacity than the next leading antacid.*
- **greater patient acceptance**—over 25 years' experience with millions of patients.
- **less costly**—50¢ less per bottle than the next leading antacid.
- **less sodium**—36% less sodium than the next leading antacid.

Minty Maalox. Well tolerated, month after month...year after year.

*per minimum recommended dose.

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One contains aspirin. One doesn't.

Darvocet-N® 100

100 mg. propoxyphene napsylate and 650 mg. acetaminophen

Darvon® Compound-65

65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine

Lilly

Additional information available to the profession on request.

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500341

Official Call to the 1975 Annual Session Pennsylvania Medical Society House of Delegates

The 1975 Annual Session of the House of Delegates of the Pennsylvania Medical Society will convene in the Cabaret Room of the Host Farm Motel, Lancaster, Pennsylvania, Monday, October 6, 1975, at 1:00 p.m. The second session of the House of Delegates is scheduled for Tuesday, October 7, 1975, in the Cabaret Room beginning at 1:00 p.m. The third, and concluding session of the House, will be held Wednesday, October 8, 1975, in the Cabaret Room beginning at 9:00 a.m.

Elections

Nominations and/or elections will be held at the second session Tuesday afternoon, October 7, 1975, as called for in Standing Rule No. 1 of the House of Delegates. Among the general officers to be elected by the 1975 House of Delegates will be: a Vice President, a Secretary, a Speaker of the House of Delegates, and a Vice Speaker of the House of Delegates. Also to be elected are a Trustee and Councilor for the Third Councilor District, to serve five years to succeed Ralph K. Shields, M.D., Northampton County, who is eligible for re-election; a Trustee and Councilor for the Ninth Councilor District, to serve for five years to succeed Cyrus B. Slease, M.D., Armstrong County, who is not eligible for re-election, having served two five-year terms.

Also to be elected for a two-year term beginning January 1, 1976, will be five delegates and five alternates to the American Medical Association. Delegates whose terms expire December 31, 1975 are: Wilbur E. Flannery, M.D., Lawrence County; Paul S. Friedman, M.D., Philadelphia County; John B. Lovette, M.D., Cambria County; Matthew Marshall, Jr., M.D., Allegheny County; and Malcolm W. Miller, M.D., Philadelphia County.

Alternate Delegates whose terms expire December 31, 1975 are: H. Robert Davis, Jr., M.D., Cumberland County; Lawrence D. Ellis, M.D., Allegheny County; Henry H. Fetterman, M.D., Lehigh County; John Helwig, Jr., M.D., Philadelphia County; and Robert N. Moyers, M.D., Crawford County.

As directed by Chapter XIV, Section 2 (e) of the Bylaws, the Committee to Nominate Delegates and Alternates to the AMA makes the following nominations for delegates for two-year terms commencing January 1, 1976:

1. Paul S. Friedman, M.D. (Philadelphia County)
2. John B. Lovette, M.D. (Cambria County)
3. Matthew Marshall, M.D. (Allegheny County)
4. Malcolm W. Miller, M.D. (Philadelphia County)
5. Robert N. Moyers, M.D. (Crawford County)

The Committee makes the following eight nominations for five alternate delegates for two-year terms commencing January 1, 1976:

1. Arthur C. Crovatto, M.D. (York County)
2. Frank J. Dracos, M.D. (Monroe County)
3. Lawrence D. Ellis, M.D. (Allegheny County)
4. Henry H. Fetterman, M.D. (Lehigh County)
5. Wayne W. Helmick, M.D. (Beaver County)
6. John H. Helwig, Jr., M.D. (Philadelphia County)
7. David J. Keck, M.D. (Erie County)
8. David L. Mudrick, M.D. (Delaware County)

Also to be elected will be two members to serve on the Committee to Nominate Delegates and Alternates to the American Medical Association. One election is required to fill the position of John V. Blady, M.D., Philadelphia County, whose term expires and who is eligible for a second three-year term. The second election is required to fill the position of Charles K. Zug, III, M.D., Northampton County, who was elected in 1974 to complete the final year of the three-year term of Edgar W. Meiser, M.D. Dr. Zug is eligible for election to a full three-year term.

Also to be elected is a District Censor from each component medical society to serve for one year following the close of the 1975 House of Delegates Session.

The component county medical societies have submitted the following nominations for District Censor:

Adams, **James Allison;** Allegheny, **William D. Stewart;** Armstrong, **Arthur R. Wilson;** Beaver, **Herman Bush;** Bedford, **G. L. Rinard;** Berks, **Brian A. Wummer;** Blair, **John W. Hurst;** Bradford, _____; Bucks, **Stanley F. Peters;** Butler, **Robert C. McCorrey;** Cambria, **Warren F. White;** Carbon, _____; Centre, **H. Richard Ishler;** Chester, **Grant W. Bamberger;** Clarion, **Theodore R. Koenig;** Clearfield, **Fred Pease;** Clinton, **George J. Treires;** Columbia, **James F. Youngkin;** Crawford, **David D. Kirkpatrick, Jr.;** Cumberland, **Hans S. Roe;** Dauphin, **Robert P. Dutlinger;** Delaware, **Richard W. Garlichs;** Elk-Cameron, **Robert J. Dickinson;** Erie, **Robert L. Loeb;** Fayette, **Veronica Binns;** Franklin, **Albert W. Freeman;** Greene, **David L. Avner;** Huntingdon, _____; Indiana, **Stephen J. Takach;** Jefferson, **Nicholas F. Lorenzo;**

Lackawanna, **Normal S. Berger;** Lancaster, **William G. Phippen;** Lawrence, **Gerald H. Weiner;** Lebanon, **C. Ray Bell, Jr.;** Lehigh, **Frederick A. Dry;** Luzerne, **Samuel T. Buckman;** Lycoming, **Franklin G. Wade;** McKean, **Bruno P. Sicher;** Mercer, **Frank E. McElree;** Mifflin-Juniata, **Donald E. Basom;** Monroe, **Claus G. Jordan;** Montgomery, **Rudolph K. Glocker;** Montour, **Robert L. Gatski;** Northampton, **Walter J. Filipek;** Northumberland, **J. Mostyn Davis;** Perry, **James O. Rumbaugh, Jr.;** Philadelphia, **Charles M. Thompson;** Potter, **H. C. Mosch;** Schuylkill, **Joseph T. Marconis;** Somerset, **Alexander Solosko;** Susquehanna, _____; Tioga, **Lane H. Webster;** Union, **Joseph Weightman;** Venango, **Robert L. Taylor;** Warren, **Donald Jack Furman;** Washington, **Joseph N. McMahan;** Wayne-Pike, **Emil T. Niesen;** Westmoreland, **Leslie S. Pierce;** Wyoming, **John S. Rinehimer, Jr.;** York, **Donald R. Gross.**

Proposed Amendments to the Constitution and Bylaws

Printed below is the text of the amendments to the Constitution and Bylaws which are being proposed by the Committee on Constitution and Bylaws.*

**Material underlined is being added. Material in brackets is being deleted.*

Subject One

1. Elimination of Campaign restrictions

Bylaws

Chapter IV—Elections

Section 3. Disqualification for Office. [Any person known to have solicited votes for himself or sought after any office within the gift of this Society shall, after a determination to that effect by a two-thirds vote of the members of the House of Delegates present and voting, be ineligible for any office for a period of two years after the related election.]

(Secretary' Note; Three-fourths vote required.)

Subject Two

2. Continuing Education Requirement—Change of Dates

Constitution

Article IV—Membership

Section 12. Continuing Medical Education Requirement. In order for an Active or Senior Active dues-paying or Associate Member of this Society to remain a member in good standing of the Society after [December 31, 1975] June 30, 1976, he must show evidence of engaging in continuing medical education as prescribed by the Bylaws of this Society.

(Secretary's Note: Two-thirds vote required.)

Bylaws

Chapter I—Membership

Section 5. Continuing Medical Education Requirement. In order for an Active or Senior Active dues-paying or Associate member of this Society to remain a member in good standing of the Society after [December 31, 1975] June 30, 1976, he must have qualified for the American Medical Association's Physician's Recognition Award, which award is currently based upon a three-year [continuing medical education program, which in this instance commences on July 1, 1972] qualifying period. Each Active or Senior Active dues-paying or Associate member, one he has qualified for the American Medical Association's Physician's Recognition Award, must continue to qualify for such award in order to remain a member in good standing of the Pennsylvania Medical Society. The Board of Trustees and Councilors shall, in accordance with procedures established by such Board, have the power to waive such requirements in those cases involving Active or Senior Active or Associate members of this Society serving temporarily in the Armed Forces or other Government service of the United States or prevented from the practice of medicine by reason of illness or disability or in such other cases as in its judgment such waiver should be granted. The Board shall waive such requirements upon application from any Associate member not actively engaged in the practice of medicine. Special student members are exempt from the Continuing Education Requirement.

(Secretary's Note: Two-thirds vote required.)

Chapter I—Membership

Section 6. Suspension from Membership. The membership of a member in this Society shall be suspended (a) on December 31 of any year (beginning in [1975] 1976) if he is an Active or Senior Active dues-paying or Associate member who has failed to qualify for the American Medical Association's Physician's Recognition Award provided the Office of the Executive Vice President has given such member sixty days notice prior to December 31 that such suspension will be invoked against him unless such member shall submit sufficient supplemental records to fulfill such award requirements by December 31, and such suspension shall be for a period of one year; (b) upon suspension of his membership in his Component Society; and (c) upon the effective date, as provided in Section 7 of Chapter XIII of these Bylaws, of an order to that effect issued by the Judicial Council of this Society. The suspended member shall not be entitled to exercise any of the rights or privileges of membership during the period of suspension, shall be required to continue the payment of annual assessments without any reduction whatsoever, and shall be restored to full membership upon the expiration of the period of suspension provided he has qualified for a current AMA Physician's Recognition Award Certificate.

(Secretary's Note: Three-fourths vote required.)

Subject Three

3. Removal of Unnecessary Language re: Composition of Judicial Council

Constitution

Article IX—The Judicial Council

Section 5. Composition. The Judicial Council shall consist of five members, qualified as provided in Section 6 of this Article IX, elected by the House of Delegates on

nomination by the Board of Trustees and Councilors or from the floor of the House, for terms of three years. [At the time this amendment becomes effective, one member will be completing his first year, one his second year, one his third year, and one his fourth year of five year elected terms, and one member shall be completing his five-year term thereby creating a vacancy which shall be filled by electing one member for a term of three years, and in the case of the remaining four members, those members with two years and one year remaining of their five-year terms shall remain in office for a period of one year, at the end of which period such two positions shall be filled by electing two persons for terms of three years each; and those members with four and three years remaining of their five year terms shall remain in office for a period of two years, at the end of which period such two positions shall be filled by electing two members for terms of three years each. Thereafter, in the first year, one position will be filled for a term of three years; in the second year, two positions will be filled for periods of three years; and in the third year, two positions will be filled for periods of three years; and so forth thereafter.] At least thirty days prior to each Annual Session of the House of Delegates, the Board of Trustees and Councilors shall nominate at least three qualified persons for each vacancy on the Judicial Council and shall promptly publish their names to the membership of this Society in the Journal of this Society, if there be such, or by some other appropriate means; however, the failure of the Board to nominate any, or a sufficient number of, candidates or to publish their names shall not invalidate any election which is otherwise validly conducted by the House of Delegates. The Judicial Council annually shall select, at its first meeting, a Chairman and a Vice-Chairman who shall be members thereof. The Secretary of this Society shall serve as Secretary of and alternate member of the Council. The Secretary shall become a voting member of the Judicial Council when any regular member thereof shall be unable to attend a meeting. In any event three members, including the alternate member, shall constitute a quorum, without which the Council can not properly conduct its business.

(Secretary's Note: Two-thirds vote required.)

Subject Four

4. Automatic Suspension for Guilty and Nolo Contendere Pleas

Bylaws

Chapter XIII—Disciplinary Proceedings and Appeals

Section 9. Automatic Suspension. Any member of this Society convicted by a court of competent jurisdiction of the commission of a felony or any crime involving moral turpitude, shall be automatically suspended for an indefinite period. It shall be the duty of the Secretary promptly to inform the appropriate county board of censors of any such conviction of any member of this Society; however, any member of the Society, having any such information should promptly report the same to the county board of censors. The county board of censors shall make due inquiry and if it finds that such member has, in fact, been so convicted, it shall order a certified copy of the conviction from the court and upon receipt thereof it shall be filed with the member's records. The county board of censors shall thereupon notify the member that he will stand suspended from membership for an indefinite period, beginning ninety days following his conviction by the court, or ten days following the notice if such notice is issued more than ninety days after the conviction, unless prior to the effective date of the suspension, the member certifies to the county board of censors that he has filed an appeal from the conviction. If the member so convicted has so appealed, the suspension from membership shall be stayed until such time as the appeal has been finally disposed of by a court of last resort, and such suspension shall be completely nullified in the event that the conviction of the member is reversed by such court. Conviction, as used in this section, shall include a finding or verdict of guilt, an admission of guilt or a plea of nolo contendere.

(Secretary's Note: Three-fourths vote required.)

Subject Five

5. Expansion of Privileges for Associate Members

Constitution

Article IV—Membership

Section 4. Associate Member. An Associate Member of this Society shall be a physician who (i) is seventy years of age or over and (ii) has been an Active or Senior Active Member of this Society, a service member of the American Medical Association, or an active member of a constituent association of the American Medical Association for a continuous term of thirty years. Such Associate Member shall have the right to this class of membership upon certification in due form by the Component Society to the Executive Vice President of this Society; and thereafter such Associate Member shall not be required to pay any annual assessment, but may be charged reasonable fees for services.

(Secretary's Note: Two-thirds vote required.)

Article IV—Membership

Section 10. Rights and Privileges of Members, Including Voting Rights. All members of the Society shall have all of the rights and privileges of membership except as otherwise provided in this Constitution and the Bylaws and except that neither [Associate nor] Affiliate nor Honorary Members shall have the right to vote or hold any office or to be members of any council, committee, or commission.

Each Special Student Member shall serve as a delegate in the House of Delegates with the right to vote and to serve on reference committees, with the exception of the Reference Committee on Constitution and Bylaws; but no Special Student Member shall have the right to hold any office or to be a member of any council, commission, or committee.

No member of this Society of any class shall have any direct vote in the affairs of this Society except as to

such matters, if any, where such vote is required by the laws of the Commonwealth of Pennsylvania.
(Secretary's Note: Two-thirds vote required.)

Article VI—House of Delegates

Section 2. Composition. The House of Delegates shall be composed of (a) delegates (or their alternates) elected by the Component Societies in the proportion for one delegate for every hundred or fraction thereof of its Active, Senior Active, Associate, Intern and Resident Members in this Society whose dues are paid or excused as of December 31 of each preceding year, whose term of office shall be for a term of one year or for a term in excess of one year if such Component Society's Bylaws provide for a longer term than one year provided that at least one delegate or alternate be elected by such Component Society each year, and whose names have been submitted to the office of the Executive Vice President of the Pennsylvania Medical Society as instructed by the Executive Vice President, and in January of each year the Executive Vice President of the Pennsylvania Medical Society shall certify to each Component Society the number of delegates to which it is entitled during the current year; (b) the secretaries of the Component Societies in office at the time of any meeting of the House of Delegates; (c) specialty section members, delegates elected by the American Medical Association Board certified specialties having organized societies in Pennsylvania on the basis of one delegate for each such specialty society, such specialty delegates shall be Active, Senior Active, Associate, Intern, or Resident Members in good standing in this Society; (d) special student members (or their alternates) as defined in Sections 9 and 10 of Article IV; and (e) ex-officio, but without the right to vote, the Speaker, Vice Speaker, and Immediate Past Speaker, of the House of Delegates, the President, President Elect, Vice President, the Secretary, the Trustees and Councilors, and the members of the Judicial Council of this Society, the ex-presidents of this Society and the presidents of the Component Societies, except that any of the foregoing ex-officio delegates, other than those prohibited from so doing by Article V of this Constitution, may at the same time serve as voting delegates duly designated as such by the respective Component Societies, and except that the Speaker, or the Vice Speaker when serving as Speaker, shall have the right to vote in all cases where his vote would change the result of a vote taken other than a vote decided by ballot.
(Secretary's Note: Two-thirds vote required.)

Article VI—House of Delegates

Section 3. Alternates. Component Societies shall be entitled to elect at the time of electing delegates two alternates-at-large for each delegate, who shall take office, serve for the term, and be certified to the office of the Executive Vice-President, as set forth in Section 2. Alternate delegates shall be seated as determined by the Chairman of the delegation from each county society, or in the absence of the Chairman, the Secretary of the county society, or in the absence of either of these by the Credentials Committee. No Chairman of a delegation shall have the power to unseat a delegate involuntarily.

Specialty societies shall be entitled to elect at the time of electing their delegate, one alternate. Such alternates shall be Active, Senior Active, Associate, Intern, or Resident Members in good standing in this Society.

Although automatically an ex-officio member of the House without the right to vote (Section 2) the President of any Component Society may be elected as one of the county's regular elected delegates or alternates, pursuant to the customary rules of electing delegates and alternates to the House of Delegates.

If any Component Society is without any duly accredited voting member of the House of Delegates at any session thereof, then the Active, Senior Active, Associate, Intern or Resident Member or Members registered in attendance from that Component Society may select himself or one delegate from their number, as the case may be, who shall be the representative of that Component Society and shall serve in the place of an accredited delegate.

If any special student member is unable to serve he may designate an alternate to serve in his place from the active membership of his Chapter of the Student American Medical Association.
(Secretary's Note: Two-thirds vote required.)

Article VII—Sessions and Assemblies

Section 2. Special Sessions. Special sessions, either of this Society or of the House of Delegates, may be requested at any time by (a) nine members of the Board of Trustees and Councilors, or (b) forty voting members of the House of Delegates, or (c) two hundred Active, Senior Active, Associate, Intern and/or Resident Members of this Society, provided such special session has the approval of the Component Society or Societies having an aggregate membership of at least 200 physicians, for the transaction of such business as is proper and set forth in the request for call. Such request shall be in writing and delivered to the Secretary, and thereupon the Secretary shall fix the time and place for the session, which shall be not less than forty and not more than ninety days after receipt of the request, and shall call the session by appropriate notice, which shall state the purpose and shall be made in the manner provided in Section 1 of this Article VII except that the original call shall be issued no later than thirty days prior to the holding of the session.
(Secretary's Note: Two-thirds vote required.)

Article VII—Board of Trustees and Councilors

Section 2. Composition. The Board of Trustees and Councilors shall consist of the President, the President Elect, the Vice President, and the Immediate Past President, ex-officio with the right to vote, and the Speaker and the Vice Speaker of the House of Delegates, ex-officio without the right to vote, and one Active, Senior Active, Associate, Intern or Resident Member from

each Councilor District of this Society as determined by the Bylaws. Each Trustee and Councilor shall be elected for a term of five years and shall serve until his successor shall have been elected and qualified. No Trustee and Councilor shall serve more than two consecutive terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless he has served more than two years, and for this purpose a year shall be deemed to be the period between annual sessions of the House of Delegates.

Article X—Officers

Section 2. Qualifications. All officers of this Society must be Active, Senior Active, Associate, Intern or Resident Members, except that the Treasurer may be a corporation or an employee of this Society and the Assistant Treasurers and Assistant Secretaries may be employees of this Society. The Speaker and Vice Speaker must be members of the House of Delegates at the time of their election.

(Secretary's Note: Two-thirds vote required.)

Article XV—Amendments

The House of Delegates may amend this Constitution at any session by an affirmative vote of two-thirds of the delegates present provided the text of the proposed amendment has been (a) submitted not less than four months, and not more than fifteen months, prior thereto, to a session of the House of Delegates, or to the Secretary of this Society by (i) the Committee on Constitution and Bylaws, if the Bylaws provide for such committee, or (ii) fifteen Active, Senior Active, Associate, Intern and/or Resident Members of this Society, whose signatures shall be appended thereto and (b) at least two months prior thereto, published in the JOURNAL of this Society, if there be such, and in the call for the session. The House of Delegates may determine the effective date of any amendment.

(Secretary's Note: Two-thirds vote required.)

Bylaws

Chapter XIV—Committees, Administrative Councils and Commissions

Section 1. Appointment of Members, Vacancies and Qualification. . . . (d) Qualification for Membership on Committees, Administrative Councils and Commissions. All members of this Society, except [Associate,] Affiliate, Honorary and Special Student Members, shall be eligible to serve as members of committees, administrative councils and commissions, except that:

(i) No member of the Judicial Council shall be eligible for appointment to (a) any administrative council or commission, or (b) any committee, membership of which is prohibited by Article V of the Constitution.

(ii) The President, the President Elect, the Vice President and members of the Board of Trustees and Councilors shall not be appointed members of any standing committee, administrative council or commission unless required by these Bylaws.

(iii) No member shall serve concurrently as (a) a member of more than one administrative council or commission, or (b) a member of more than one commission and one standing committee, or (c) as an appointed member of more than two standing committees.

(iv) No member of an administrative council, committee or a commission shall serve more than six consecutive terms. For the purposes of this subsection, a member appointed to fill a term or unexpired term of less than one-half the regular term of that appointment shall not be deemed to have served a term.

(Secretary's Note: Three-fourths vote required.)

Chapter XV—Pennsylvania Medical Care Program

Section 2. Organization.

(a) Administration of Program. The Council on Medical Service shall be responsible for general supervision of the Pennsylvania Medical Care Program throughout the Commonwealth.

The Council shall report on the Program directly to the Board of Trustees and Councilors in the interim between sessions of the House of Delegates and shall report annually to the House of Delegates as required by Section 4(b) of Chapter XIV of these Bylaws.

(b) Regional Committees. Regional committees may be appointed by the Council on Medical Service whenever deemed necessary and for whatever region deemed advisable, upon recommendation of the trustee and councilor (or trustees and councilors) of the region.

Each regional committee shall be composed of two Active, Senior Active, Associate, Resident or Intern Members of each county medical society within the region, and ex-officio, the trustee and councilor (or trustees and councilors) serving the area. The appointments shall be made upon advice of the county medical societies located within the region and shall be subject to confirmation by the Board of Trustees and Councilors. Appointments shall be for a term of one year beginning and ending with an Annual Session. Vacancies among the membership of a regional committee occurring between Annual Sessions shall be filled for the remainder of the current term by the Council on Medical Service upon the recommendation of the trustee and councilor (or trustees and councilors) of the region.

A regional committee shall elect its own chairman. It shall be responsible for coordinating the activities of the Pennsylvania Medical Care Program within the designated region. Upon request, a regional committee may serve as a liaison committee to resolve medical care problems arising outside its defined region. It shall utilize to the fullest extent all existing control mechanisms of the county medical societies and the hospitals. Matters within the jurisdiction of the grievance committee of a county medical society shall be referred to said grievance committee.

A regional committee shall report periodically to the Council on Medical Service, such report period to be determined by the Council on Medical Service. Minutes

of each meeting of a regional committee shall be submitted to the Council on Medical Service and to the office of each county medical society within the region within fifteen days after each meeting. In addition, the regional committee immediately shall send a written report to the county medical society of any action taken affecting one of its members.

(c) Sub-committees. Each regional committee may establish whatever sub-committees it deems necessary to implement the Pennsylvania Medical Care Program within the region. A regional committee shall be responsible for defining the purpose of the sub-committee, including the number of members to serve thereon. Establishment of and appointments to sub-committees shall be subject to confirmation by the Council on Medical Service.
(Secretary's Note: Three-fourths vote required.)

Chapter XVI—Component Societies

Section 10. Delegates to this Society. Each Component Society shall at some meeting held prior to June 1 of each year elect, from among its members who are Active, Senior Active, Associate, Intern or Resident Members of this Society, delegates and alternates to the House of Delegates of this Society in accordance with the provisions of Article VI of the Constitution. A Component Society may, if it so desires, hold the election of such delegates and alternates during the preceding year. In such event the Bylaws of the Component Society shall contain appropriate provisions for determining the manner in which the elected delegates and alternates shall be reduced should they prove to be a number in excess of those to which the Component Society is entitled on the basis of the number of its members as of December 31 of such preceding year, and appropriate provisions for the designation prior to June 1 of additional alternates and delegates should the Component Society be entitled to more than those elected at the earlier election.
(Secretary's Note: Three-fourths vote required.)

Subject Six

6. Reintroduction of Incorrectly Edited Amendment

Bylaws

Chapter XVI—Component Societies

Section 3. Remembering that the Component Society is the only portal to this Society and to the American Medical Association, each Component Society shall make a thorough investigation of initial and transfer applicants for membership therein, including a formal inquiry to the Biographic Department of the American Medical Association; this Society; the State Board of Medical Education and Licensure; and the Credentials Committee of each hospital where the applicant holds, or most recently held, privileges; so that only reputable physicians, licensed to practice their profession in Pennsylvania, and only bonafide interns and residents may be admitted to active membership in the Component Society. Certification of completion of such investigative processes shall be certified to this Society by the chairman of the county board of censors.
(Secretary's Note: Three-fourths vote required.)

continuing education

This issue carries no education course listings. The January issue contained a supplement—a comprehensive list of education courses being offered in all parts of Pennsylvania. Consult that issue or write for a copy of the supplement to: Pennsylvania Medical Continuing Education Institute, 20 Erford Rd., Lemoyne, PA 17043.

Cervical neck mass—a rationale of management

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The diagnosis and management of a cervical mass must proceed in a thorough and systematic fashion. All too frequently, patients may present at an early stage with tumors of the head and neck at which time the salvage rate can be extremely high. However, because of mismanagement, misdiagnosis, or lack of patient concern, these lesions can go unrecognized or undiagnosed until the possibility of a definitive cure is greatly reduced.

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The purpose of this paper is to discuss the proper management of the patient who presents with a cervical mass which may be the first manifestation of a malignant tumor of local or distant origin. The neck mass should not be considered the site of the primary disease process. The individual who has an obvious primary elsewhere is not a diagnostic problem, but even in this situation one should be aware of certain fundamental principles in the management of this patient.

A thorough history is of inestimable value when evaluating the patient presenting with a neck mass. A history of hoarseness, dysphagia, hemoptysis, soreness in the oral cavity or throat, change in the fit of dentures, epistaxis, nasal obstruction, or pain radiating to the ear are extremely important and should be specifically elicited in patients presenting with any neck mass.

A complete and thorough examination of the head and neck is mandatory. This should include examination of the nasopharynx by mirror examination, direct visualization, examination by anterior rhinoscopy, nasopharyngoscopy and by palpation if necessary. Examination of the nose is important as well. The physician must not ignore the fact that the patient may be wearing dentures and therefore, all dentures are removed in order to complete a thorough examination. The retromolar trigone, which is situated lateral to the tongue and begins posteriorly opposite the second molar must be well visualized. When mirror laryngoscopy is performed, one does not evaluate only the status of the vocal cords, but the subglottic area, base of tongue lateral pharyngeal walls, the pyriform sinuses and hypopharynx.

Examination must include bimanual palpation of the tongue and floor of the mouth and other areas if indicated. A systematic palpation of the neck is conducted including the thyroid and supraclavicular areas as well as evaluation of the motility of the entire larynx. In addition, one should observe the scalp and neck skin for lesions of these areas. Malignant melanomas particularly, can present as a mass in the neck. A unilateral serous otitis media should suggest a nasopharyngeal lesion. The presence of a neck mass and a serous ear is almost diagnostic of a nasopharyngeal neoplasm, and with these findings such a lesion is considered to be present until definitely excluded.

When functional pathologic changes of the thyroid gland are excluded, approximately 20 percent of cervical masses which occur in

the neck are of benign etiology.[1] However, the remaining 80 percent are malignant and consequently any mass presenting in the neck must be considered to be malignant until proven otherwise. An open biopsy should not be performed when an isolated neck mass is encountered. The procedure can result in the opening of tissue and fascial planes with subsequent seeding of tumor and marked decrease in survival rates. It may also require adherence to a less than optimum plan of therapy in order to deal with the prior biopsy. Instead, every attempt must be made to locate a primary lesion since the type, location and extent of this primary lesion may significantly alter the proposed plan of treatment. The needle, incisional or excisional biopsy is only utilized when all other efforts have been exhausted.[2,3]

Benign lesions of the neck

Benign lesions which can present as isolated neck masses are usually of three types: benign neoplasms, developmental abnormalities, or of inflammatory origin.

Benign tumors of the neck are relatively common and can be readily confused with those of a malignant nature. Among the more common of these are those involving the thyroid gland including goiter and Hashimoto's disease (subacute thyroiditis). Benign lesions of the salivary glands, most often of parotid gland origin, can frequently project from the tail of the gland into the upper neck below the angle of the mandible. Benign mixed tumors, Warthin's tumor, and adenomas are the most common of these benign lesions.[4] Other less common benign tumors one may encounter are lipomas, neurofibromas, chondromas and carotid body tumors. The carotid body tumors will be encountered at the level of the carotid bifurcation with definitive diagnosis offered by means of angiography. Clinically a bruit will usually be heard over the tumor mass.

Developmental abnormalities can present as an isolated neck mass. The most common is the thyroglossal duct cyst. Others include branchial cleft cysts, dermoid cysts, cystic hygromas, laryngoceles and esophageal diverticulum.

Thyroglossal duct cysts can be observed anywhere near the midline from the foramen cecum to the supra-sternal notch and usually will move up or down as the patient swallows. If the mass is sublingual in location it is especially important to obtain a thyroid scan to be sure there is functioning thyroid tissue present beyond the mass for this mass could represent a sublingual thyroid gland.

Cystic hygromas are related to developmental problems involving lymphatic channels. This mass will often transilluminate. Surgery should be considered only if there is a significant cosmetic or functional problem, since total excision is often impossible.[5]

Dermoid cysts can present in a similar manner to a thyroglossal duct cyst and clinically they frequently cannot be differentiated.

Branchial cleft cysts may occur as a residual of the first, second or third arches and are found in the lateral cervical region. The location of these cysts is usually helpful in making the diagnosis, although occasionally a thyroglossal duct cyst can be laterally placed. The first branchial cleft cyst usually opens into the external auditory canal anteriorly or on the preauricular area. The sinus extends anteriorly and inferiorly and is related to the parotid gland and facial nerve. Cysts of the second arch are usually located anterior to the sternocleidomastoid muscle. The tract crosses between the ninth and twelfth cranial nerves and between the external and internal carotid arteries before entering into the pharynx in either the tonsillar fossa or more infrequently the nasopharynx. A third arch cyst is rare and usually extends over the twelfth and under the ninth cranial nerves. It runs behind both carotid arteries and enters into the hypopharynx. Fourth arch cysts have not been reported.[6,7]

In addition to these developmental cysts there are several other lesions which must be considered. These are the laryngocele, esophageal diverticulum, and carotid aneurysm. The laryngocele is an outpouching of the laryngeal ventricle and if it presents in the neck (usually laterally) it is considered to be an external laryngocele. It is often quite soft and will often increase in size as intralaryngeal pressure is increased. It is a relatively common lesion among glass blowers and individuals who play wind instruments. As esophageal diverticulum can also present as a large mass usually anterior to the sternocleidomastoid and there may be a history of dysphagia and aspiration. Both the laryngeal and esophageal diverticuli will commonly be compressible. A carotid artery aneurysm is quite rare, pulsating mass suggesting this diagnosis. It is confirmed by angiography.

Approximately 6 percent of neck masses are secondary to lymph node involvement with inflammatory disease.[9] This can be either local reaction or secondary to systemic disease. Any acute infection of the neck can present in this manner. Acute infections may be secondary to dental disease, tonsillitis or pharyngitis. Extension of infection or breakdown of lymph nodes may result in the accumulation of pus or in subsequent abscess formation. A number of these abscesses do present in the neck as cervical masses, the specific type being determined by its anatomic location. The fascial spaces and planes of the neck limit the extent of these cervical abscesses.

Cervical mass lesions, especially when multiple, may be one presentation of a systemic disease process such as Hodgkins' disease or other lymphomas. It may be secondary to chronic inflammatory disease such as tuberculosis. Other common inflammatory diseases such as infectious mononucleosis, actinomycosis, sarcoidosis, tularemia, psitticosis and mumps may present as a neck mass. When one encounters nodes of consequence in the neck it is important to examine the patient thoroughly to determine if other areas of lymphadenopathy are present. However, one should be aware of the possibility of mistaking

a cervical metastasis for inflammatory hypertrophy of lymph nodes—something which can occur all too frequently.

Malignant lesions of the neck

As previously stated, any mass in the neck should be considered to be metastatic cancer from a primary carcinoma of the head and neck until proven otherwise. Of these malignant neck masses 85 percent are of neck origin, 9 percent are from a distant primary lesion, 5 percent are from an occult or hidden lesion, and 1 percent present as the first symptom of a constitutional or systemic neoplasm.[8]

When a patient has a neck mass he will usually have other signs and symptoms which aid the physician in determining the site of the primary lesion. Not infrequently, the primary lesion can be completely asymptomatic and it is in these instances that the physician's acumen must be at its best.

After a complete examination is performed and difficulty is encountered in locating the primary lesion, certain factors must be considered. A lesion that lies in the midline is most likely to be a congenital abnormality such as thyroglossal duct cyst. The relationship to the sternocleidomastoid muscle is extremely important. Carcinomas usually present anterior to, in, or under the sternocleidomastoid and are usually metastatic lesions. A single neck mass is more likely to be of a malignant nature. Multiple masses suggest inflammatory or systemic disease. The physical characteristics of the mass are important. A cystic, soft or tender lesion is most likely to be benign. If the lesion is hard, fixed and nontender, the possibility of this lesion being neoplastic is extremely high.

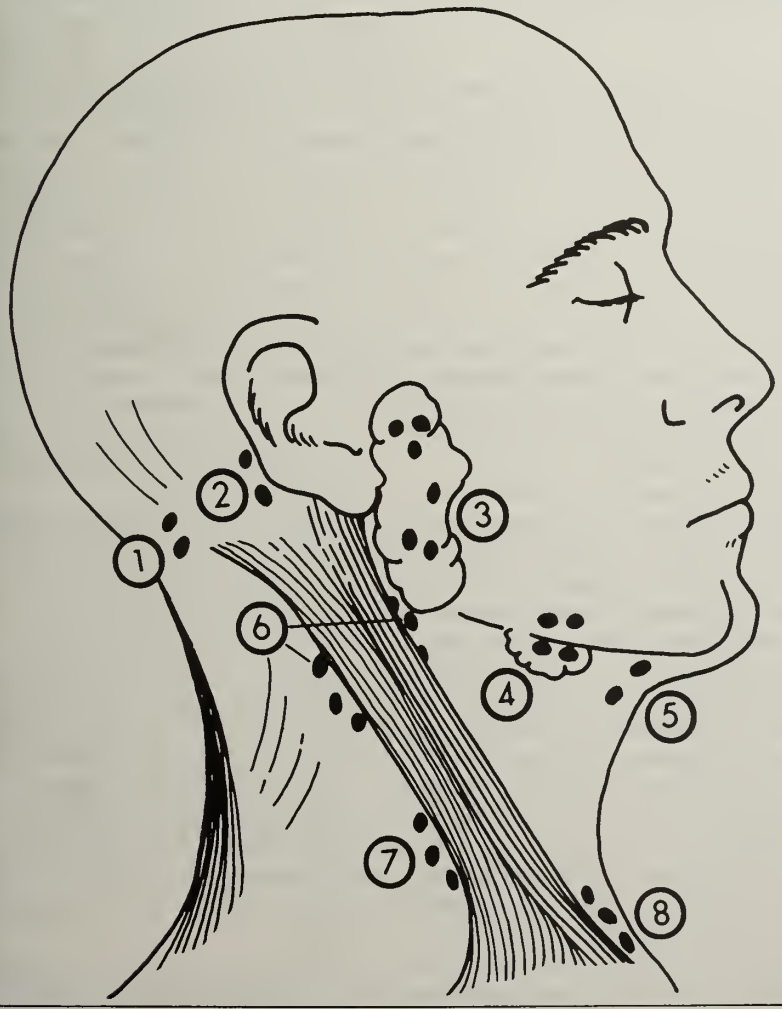

Figure 1: Major lymph node groups of the cervical region: (1) Occipital; (2) Mastoid (post-auricular); (3) Parotid (pre-auricular); (4) Submaxillary; (5) Submental; (6) Upper cervical (upper jugular); (7) Lower cervical (lower jugular); (8) Anterior cervical.

The location of the neck mass may be helpful in certain instances. There are specific lymphatic drainages from different areas of the head and neck and consequently metastatic spread is usually via these routes (Figure 1). The submental nodes drain the lip, the anterior floor of the mouth, and the buccogingival area. The submandibular nodes drain the cheek, buccal mucosa, anterior two-thirds of the tongue, the anterior floor of the mouth and lateral buccogingival sulcus. The subdigastric or jugulodigastric nodes drain the tongue, pharynx, tonsil and ear. These are the nodes that are usually involved in acute tonsillitis or pharyngitis in children. The mid-jugular nodes will most frequently drain the posterior and lateral gingival wall, the pyriform sinus area, the intrinsic larynx and supraglottic areas. Extension to the lower jugular nodes is suggestive of a thyroid lesion, laryngeal lesions below the epiglottic level and primary lesions below the clavicle. Involvement of the anterior scalene nodes suggests lesions below the clavicle, most commonly lung or stomach.

The most common sites of primary disease which can present initially as an isolated neck mass are the nasopharynx, tonsil, and base of tongue with the supraglottic larynx, thyroid gland, pharynx, floor of mouth and palate being less frequently responsible (Figure 2).[9] Squamous cell carcinoma is present in the majority of cancer bearing cervical nodes. Undifferentiated carcinoma, lymphoepithelioma or lymphosarcoma are less frequently encountered. Adenocarcinoma is found in approximately 10 percent of cases.[3]

No primary lesion will be initially discovered in approximately 5 percent of malignant cervical masses.[9,10,11] This statement must be made only after a thorough search for a primary lesion of the head and neck region and distant

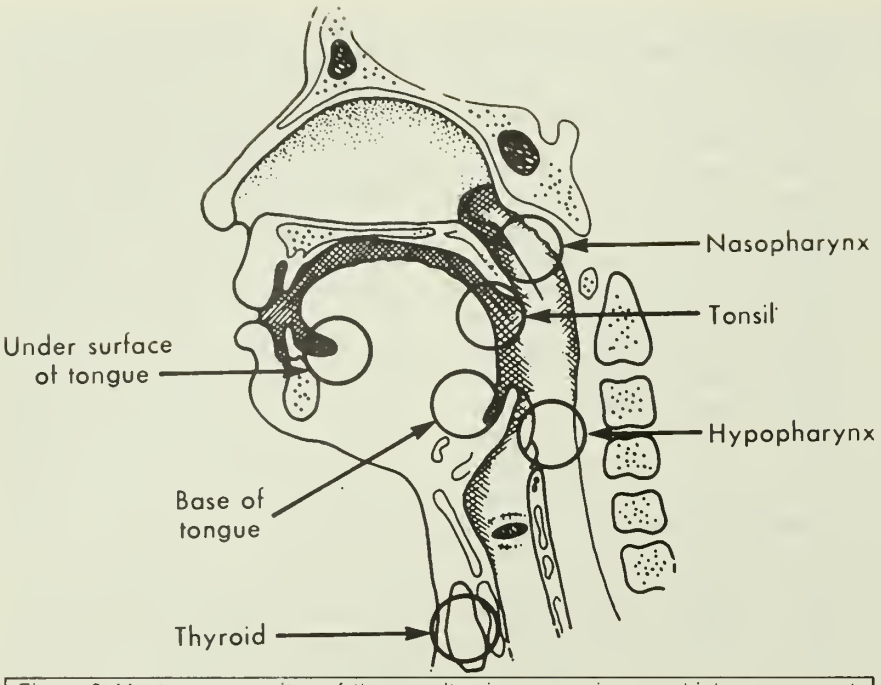

Figure 2: Most common sites of the occult primary carcinoma which can present initially as a neck mass.

sites is instituted. Workups in these patients include x-rays of the chest, sinuses and nasopharynx. A barium swallow and thyroid scan should also be obtained as well as tomograms of the larynx and a laryngogram. Direct laryngoscopy, bronchoscopy and esophagoscopy are then performed and any "questionable" area is biopsied. It is also valuable to perform a biopsy of the nasopharynx even if no lesion is noted in this area, the so-called "blind" biopsy. If all of these possibilities have been considered, only then could a biopsy of the mass itself be contemplated. A tissue specimen may be obtained by either a needle biopsy or by the open biopsy method. The needle biopsy is often preferred. The possibility of tumor dissemination is much less likely with needle biopsy, with the needle track being placed so it can be widely excised in any definitive surgical procedure. The aspiration will determine if the tumor is cystic or solid type. Unfortunately, this technique is not usually reliable for lymphomas, salivary gland tumors or thyroid tumors. The needle biopsy may not provide a definitive diagnosis as the specimen may have been obtained from an adjacent area to the tumor and any negative biopsy is considered to be of no value. If the biopsy does not provide a positive diagnosis, the next procedure is then open biopsy with frozen section. The patient must be informed that if a positive biopsy is obtained on frozen section, a definitive procedure, usually a radical neck dissection will be performed at that time. If a neck dissection is not performed, a complete course of radiotherapy is given to this area of the neck. When a definitive diagnosis cannot be provided by frozen section, the incision is closed and further treatment is deferred until examination of the permanent tissue sections. Survival rates appear to be favorably influenced with radiotherapy to the neck area and even more so when definitive surgery (usually a neck dissection) is employed instead of simple excision of the mass.[2,12] Treatment, either surgery or radiotherapy, must not be postponed if the primary lesion cannot be found.

Even when a definitive procedure is performed, a continued search for the primary lesion must be continued. A primary lesion will become apparent in approximately 50 percent of these occult tumors at a later date.[2,9] More than half of these late presenting tumors will appear in the nasopharynx with the remainder usually situated in the tonsil, thyroid, or base of tongue (Figure 2). Pulmonary and gastrointestinal neoplasms are the most frequent lesions presenting in this manner. If an adenocarcinoma is encountered, x-ray of the upper and lower gastrointestinal tract, intravenous pyelograms, mamograms in women and thyroid scans should be obtained.[12] Winegar has recommended repeating these studies at 3 to 6 month intervals.

The presence of an isolated neck mass presents a diagnostic and therapeutic challenge which must be approached in a systematic and thorough fashion. Over 80 percent of these lesions will prove to be malignant and represent a metastatic form of tumor. Consequently, every attempt must be made to locate the primary tumor. Unfortunately, no primary lesion will be found in approximately 5 percent of patients with isolated neck masses which prove to be malignant. After all diagnostic modalities have been exhausted, a needle and/or open biopsy is performed usually followed by radical neck dissection if squamous cell or adenocarcinoma is encountered. Even after surgical treatment a continuous search must be maintained for the primary origin of the neoplasm. □

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practice management

Merging existing practices—practical considerations

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'Group practice has both pros and cons, but if it is to be entered by merger of existing practices it must be handled with extreme care. . . . handling must include competent and experienced outside advice, honest dealings between the doctors themselves and a considerable amount of their time and attention.'

The increased popularity and success of group practice has caused many doctors to consider joining together with other doctors already in practice. Increasing numbers are in fact merging.

Why merge?

While there may be a variety of circumstances involved, the following example illustrates some of the factors fueling the growing trend. Dr. X, 53 years old, and Dr. Y, 38 years old, are the only two urologists on the staff of a hospital in a growing suburban locale. Dr. X has been practicing in the area for nearly twenty years, Dr. Y for five years. The only urologists in the area, they have come to depend on each other for coverage on nights, weekends, and during vacations. Dr. X has reached the stage of his career where he is seeking more free time to spend with his growing family and he is looking ahead to retirement in ten or twelve years; Dr. Y, while younger, similarly feels the pressures of his busy practice and its demands upon his time and family.

After considerable soul searching, both physicians concluded that merger was the answer. They recognized the strong bond arising from their coverage needs. Each had seen many of the other's patients during hospital coverage; hence, each doctor understood well how the other doctor practiced and thought. The doctors had some of the professional stimulation derived from intelligent discussions of medical cases and problems, often lacking by solo practitioners, but they sought even more and believed they could get it by working together even more closely. What is more, some of the higher billing expenses, office expenses, legal and accounting costs, and the like, of the separate practices seemed at least partially avoidable.

It also appeared that the doctors' practicing as one economic unit would provide some degree of income protection if one of them should be disabled due to illness or injury for any extended period. While great care has to be exercised to assure that such arrangements not penalize the "healthy" doctor, the concept of a continuing practice providing support is extremely important. The same can be true to a limited extent upon one doctor's death, retirement or other required departure.

The example given above is one of the clearest cases in favor of merger, but so many others confirm the same basic feelings. For example, we think of four pediatricians coming together from separate practices for various coverage and peer communication reasons; three general surgeons to obtain coverage and improve

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their response to referrals; and several family practitioners for cost efficiency possibilities.

Practical Merger Considerations

Once agreement has been reached that the practices should merge, numerous practical matters must be faced. The following list is by no means all-inclusive, but it probably shows why we feel that the doctors *must* decide to meet at least once a week for at least three months to plan out all the steps and assure that their thinking is on a common wave length.

Professional advice—There are many technical legal and tax matters involved, some of a subtle nature. Expert legal, accounting and/or consulting assistance should be procured to assure that all is competently handled. We believe those advisors should do more than passively answer the doctors' questions, for the doctors may not know the right questions. The advisors should draft an extensive memo or checklist of all the details to be resolved, both technical and management-oriented. They should be able to recommend specifically on most of the items, drawing on specific prior experience as well as on technical tax, accounting and legal rulings. Failure to obtain proper guidance on some of these items can have disastrous economic effects. For example, several practices can merge in a variety of ways to accomplish the same end result but with drastically different tax liabilities.

Income division—The most important decision the doctors must make is how to divide income. If this question cannot be resolved the merger will either never result, or a breakup arising out of conflict over income division will result shortly after the merger.

The most common ways of dividing income are equally, on the basis of production, or a combination of the two.

Without delving into the pros and cons of all alternatives (which would take a whole article), we cannot stress enough that to simply say "we'll divide income equally" without reviewing the separate practices' respective financial histories could be a big mistake. For example, large disparities in the volume of practice, gross production and/or net income may require income differences to fairly reflect that contributed to the joint practice. This points out the importance of complete openness among the physicians involved as to their respective practice financial matters so all will be treated fairly and honestly. Without such openness, the practice may be starting out on the wrong foot with possible overtones of mistrust.

After the numbers have been supplied and various alternatives have been described, the respective feelings of the physicians should be aired as to the equitable division for them. This is most important to insure the happiness of the group.

Pre-merger agreement—When the doctors have agreed in principle and are committed to the merger, they might enter into a signed pre-merger agreement. This can take various forms, but it basically protects each physician from another's unilaterally pulling out after a substantial financial and professional commitment has been made. While such an agreement can prove to be useful in almost any merger situation, it is especially important when other financial and legal undertakings are involved (for example, a separate real estate partnership organized to borrow money, buy land and build a new building).

Side agreement—We would also recommend what we call a "side agreement" to serve two basic purposes. First, it would protect the "innocent" doctors and practices from pre-merger liabilities (malpractice, tax, etc.) of prior practices of which they were not a part. The "guilty" parties would either incur all liabilities personally or else indemnify those innocent of any wrong.

Second, if liability should be incurred by one or more physicians or practices as a result of activity directly relating to the merger (e.g. a tax liability imposed upon a prior practice because of the merger), this agreement would provide that the new practice and all in it would share this burden since it would not have occurred were it not for the merger. The protection should include the expenses (such as legal and accounting fees) of resisting any such claimed liabilities, since these could arise and be substantial even if there is finally found to be no actual liability at all.

New office space—A merger often results in the physical moving of both practices, since neither existing office may be large enough for the resultant practice. Thus, a variety of leasing, purchasing and construction options should be investigated. A particular problem will arise if the newly desired space is not ready for occupancy by a reasonable merger date. We have concluded in such cases that it is preferable to start the joint practice on a selected date anyway, even if in the separate, old offices just to assure that the merger actually results before the doctors' enthusiasm should wane.

A common mistake that can prove very costly is to underestimate the new practice's space needs. It can result in a prematurely forced move. Unless adequate space is obtained, inefficiencies and stunted practice growth will be experienced.

Office layout—If moving to a new office, the doctors will have an opportunity to assure that the space is laid out as efficiently as possible. Factors include how many doctors may have office hours at the same time, how many examining rooms each will need for maximum effective patient care, how many bookkeeping, typing, assisting, and other personnel will be needed, and so on. It is not just a matter of how *much* space is required, for a new practice together presents a unique opportunity to consider creatively how that space can be used for most useful traffic flow—by doctors, by ancillary help and by patients.

Assets retained and purchased—The physicians involved should survey the existing practices and decide which equipment, furnishings, fixtures and the like should be contributed to the new practice. The need to coordinate the interior design of the office could result in furniture purchases to replace older things that did not fit in.

We have often found that the assets contributed by each of the merging practices are of approximately equal value and therefore do not result in one doctor contributing substantially more than the other. However, in those cases in which there is a material disparity in the contributions, such differences can be reflected by a higher capital account balance, equalizing contributions of cash or additional income from the practice equal to any such differences.

Personnel matters—The physicians should promptly meet with the separate practice's present aides, both to inform them of the merger before rumors mislead them and to evaluate their future roles in the new office. The doctors should then discuss between them which aides should be kept and what positions each should hold. It is very important to have specific jobs for each aide, hence avoiding the all too simple result of people working together with overlapping or undefined responsibilities. Job descriptions for each aide *in writing* can help prevent such inefficiencies.

Salaries will also have to be evaluated to assure that the new offices' pay scales will not be disproportionate. Equating salaries has often been a difficult merger problem especially if two aides performing the same functions with similar expertise have been receiving grossly different salaries. Perhaps one painful observation can be kept in mind from our experiences: out of a merger it is likely that at least one excellent aide (and possibly several of them) will resign. The condition should simply be accepted as a "cost" of merger and not as a sign of the new practice's inadequacies.

It is particularly helpful for a newly merged office to deliver a jointly drafted "office policy manual" to each retained aide at the time of merger. This can standardize and set forth in writing the new practice's policies as to vacations, sick leave rights, salary raises, work evaluation periods, and the like. Since these rules may have varied among the prior practices, the writing can help avoid employee embarrassments during the essential first year after merger.

Integrating charts and records—The physicians should avoid working from separate files and should instead develop a single new filing system. Since there should be several months "lag time" before the actual merger, much of the chart and record integration can be consummated in advance. Whenever a patient comes to either office or is seen in the hospital, his old chart could be pulled and recast in the new system. Often, depending on the type of practice and the amount of "lag time," most of the active files can be so transformed with minimum disruption upon the actual joinder. If nothing is done until the merger, a disruptive situation could develop with files in various different sizes, styles, and reference systems being thrown together.

Merger is an appropriate time to review and select new filing ideas such as color coding and problem oriented systems. Color coding is especially important in a larger, merged practice, in which files generally tend to grow faster than ever, since the color identification makes it easier to weed out older files as time goes on. Failure to be prepared for such growth can be troublesome two or three years later.

The physicians should also discuss and consider uniformity in the way chart notations are made (perhaps considering the "problem oriented" system) to make it easier for the others in the group to deal with each other's patients.

Appointments and scheduling—The physicians will have to decide quite a few months before the merger date how the new practice will schedule both office and hospital work. Which mornings and/or afternoons will each doctor have office appointments? Should more than one doctor have office hours at the same time? What should be the schedule for hospital rounds, consultations and the like? Will all patients be patients of the practice, in what we often call a "true group" practice, or will each doctor see his own patients and his alone (except in emergencies or on night and weekend call)? These are important questions requiring much discussion and input to determine the proper result for a given practice and its physicians.

Appointments are often scheduled some months in advance. Therefore, these questions cannot be put off until merger. As soon as they are decided, a joint appointment book should be obtained so appointments can be correctly booked for a smooth practice start on the merger date. Besides the practicalities of making appointment plans, discussion of these matters is invaluable in helping the merging doctors assure they are on the same "wave length" as to practice philosophies.

Fee schedule—The physicians should jointly review their respective fee schedules and determine the appropriate single schedule for the common practice. Starting with the merger date, all services should be billed under that common schedule. This is important, for some doctors have been embarrassed by patients treated by several physicians in the same group and charged a different fee for the same service. The common fee schedule avoids the problem and also facilitates the aides' handling of billing, insurance work and the like.

Third party insurance—To prevent initial billing delays, an assignment account should be established with third party insurers such as Blue Shield and medicare at least a month before the merger. If one of the merging practices is already a group practice and is to be the "surviving" entity, a new assignment account may not be needed but the physicians joining in would have to be added to the account. Blue Shield's rules require notice of every doctor joining or leaving the organization's assignment account.

Opening an assignment account is not usually difficult. Usually a brief telephone call to or meeting with one's local Blue Shield Professional Relations Representative will accomplish it. A simple letter to the Blue Shield representative is required to notify of the addition of a doctor to an existing assignment account.

As an unexpected fringe benefit, a merger of practices will sometimes result in an increased fee profile for one or more of the newly merged physicians. In one

recent situation a young internist joined a senior doctor who participated in Blue Shield and had a very low profile. When the two became partners and established a single profile for the assignment account, Blue Shield used the *higher of the profiles of the two participating physicians for each procedure,* substantially raising the older physician's profile. We are not suggesting this as an overriding reason for merging, but the merger of individuals' fees can be advantageous economically.

Billing and bookkeeping systems—The billing systems of the previously existing practices should also be conformed into one effective system for the successor single practice. The resulting system should provide for the keeping of patient accounts, recording of all office and hospital work, keeping track of daily receipts and sending out of bills and insurance forms. Without a good single system, there could be confusion, wasted time and lost money.

We believe that the system should indicate how much of the charges are "produced" by each doctor, whether or not income is to be divided on the basis of productivity. Especially among new partners from diverse practices, we feel information about their relative work is vital to help them evaluate their new relationship. Lack of such clear statistical information usually will cause one or more of the doctors either to keep his own record (possibly less accurately) or to "imagine" the comparisons without a sound basis.

The bookkeeping system should be carefully reviewed with the person chosen to be the new group's accountant. The system he develops must create adequate controls over the handling of cash in the office, for a larger practice may have a much larger cash flow to be protected. We also strongly recommend that monthly statements be prepared either by a competent bookkeeper employee or by the accountant and presented to the doctors for review by perhaps the fifteenth of the following month. Such monthly statements are extremely important in well run practices, especially to new groups where careful attention during the first few months can help the doctors set the practice's direction.

Collection systems—Consideration should also be given as to the procedures to be followed in pursuing delinquent accounts so a uniform, effective policy can be established. This should be dealt with before the merger, since our experience shows that such matters tend to be ignored once the joint operation begins—until serious problems have arisen and it has already become too late to properly handle many accounts.

Office manager—Depending on the size of the resulting practice, it may be advisable to have an office manager to be responsible for some or all aspects of personnel administration, business systems and the like. Selection of a key aide from one of the pre-existing practices is one possibility, although it might present more problems than it solves if all other aides' personalities and egos might be bruised. As an alternative, an outside person might be hired to fill this special role, such person either being a full time manager without normal aide duties or a new, "super-aide."

Notices to patients and physicians—A notice should be jointly drafted and sent to patients, physicians, and others informing them of the new group practice. This notice might, within ethical restrictions on advertising, include some statement of group philosophy as a reason for joining together. Notifications suggesting that the new venture will be advantageous to the patients and referring physicians (e.g. since a physician will always be available if they call this office) may help overcome natural reservations whether things will change for the worse.

In the same respect, the receptionists in each premerger office should be trained how to respond to various questions or objections raised by telephone callers. The news of a practice change can be disquieting to faithful patients, but planned handling can smooth the way.

Patient information booklet—The time of merger is the ideal time by which to have completed and printed a "Patient Information Booklet." Such a pamphlet can include a statement of billing and collection policies, handling of third party insurance forms and other financial rules. It could also include common instructions to patients to reduce physician and aide time in repeating them so often (e.g. questions commonly asked in examining rooms, routine instructions, hospital admission procedures, and the like). Such a booklet could then be handed to each patient upon his first visit to the office after the merger, thus giving the new practice a stamp of new vitality with well thought out systems.

Technical and legal considerations—An in-depth analysis of the legal and technical considerations of a merger is beyond the scope of this article. However, we cannot stress enough that competent professional advice is a necessity since subtle and complex tax questions hide behind any merger.

Among the legal and technical matters to be dealt with is a decision as to the form of the merger. For example, should a new professional corporation be established, or should one of the predecessors remain? How can an unincorporated predecessor best be merged into a professional corporation (or vice versa)? If not handled properly, the tax consequences could be disastrous.

If a corporation is to be the resulting entity, a variety of matters such as selection of a fiscal year, amending of articles of incorporation and by-laws, drafting of new stock purchase agreements and employment agreements must also be faced. And each physician must be assured of fair and equitable treatment from both the pre-merger and post-merger pension, profit sharing, medical reimbursement and other fringe benefit plans.

Conclusion—Group practice has both pros and cons, but if it is to be entered by merger of existing practices it must be handled with extreme care. As we hope this article has shown, that handling must include competent and experienced outside advice, honest dealings between the doctors themselves and a considerable amount of their time and attention. Given these ingredients, the newly merged practice should have its best opportunity to serve the doctors and their patients well for many years. □

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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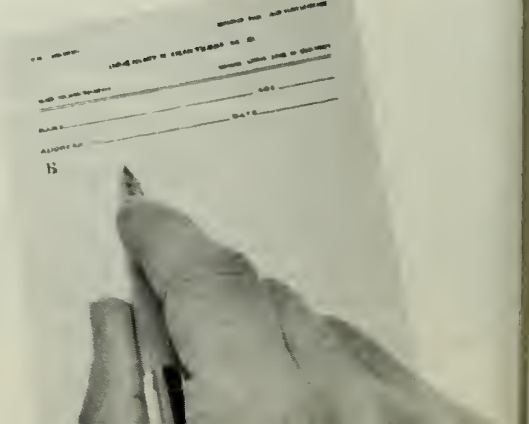
Bioequivalence



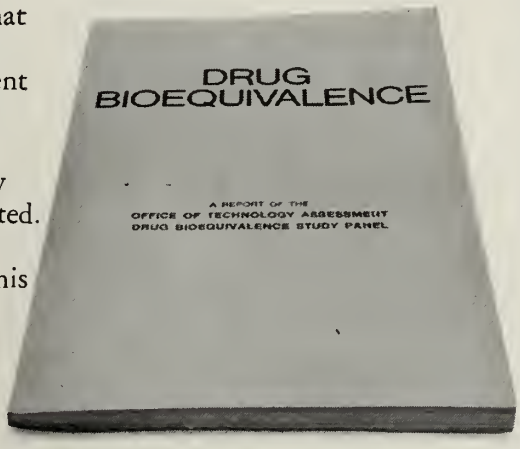
the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or

(c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

protecting the integrity of your prescription

trauma

The Irreparably Damaged Index Digit

WILLIAM P. GRAHAM, III, M.D.
STEPHEN H. MILLER, M.D.
Hershey

Accorded a value of 25 percent of the function of the hand, the index finger is regarded highly by the patient and the surgeon. Is such regard justified particularly in terms of prolonged reconstructive efforts? Probably not!

The index finger shares with the thumb the act of pinch—tip to tip, side to side, and pulp to pulp. It also performs an important role in percussive activities. Which of these functions cannot be adequately performed by the long finger? All of them can be enacted without difficulty by the middle finger. Then why is there such a preoccupation with the index finger?

The individual who has suffered irreparable damage to the index finger may be better served by its amputation than complicated attempts at reconstruction. The stiff and sometimes painful index finger is more a hindrance than an aid. Although the creed of hand surgery dictates preservation of length and restoration of function there are circumstances in which judgment dictates removal rather than reconstruction.

Amputations at the distal interphalangeal joint and beyond obviously maintain useful length, breadth of grasp, and the opportunity for pinch. More proximal ablation may still maintain palmar width and the cupping function of the palmar arch but loses the ability for pinch other than key pinch. At this point the long finger readily substitutes for all of the fine functions of the index finger.[2]

To gain better function and improve the capability of the long finger as a component of pinch, ray amputation of the index finger with transfer of the strong first dorsal interosseous muscle into the base of the proximal phalanx of the long finger may be recommended. Often this is a valuable initial procedure avoiding prolonged reconstruction procedures and extended disability of the patient. The cosmetic appearance of the hand is enhanced and function is rapidly regained with a minimum of lost time. The development of an emotional attachment to a mutilated finger is avoided.

This paper was prepared by the department of surgery, division of plastic surgery, The Milton S. Hershey Medical Center, Pennsylvania State University, Hershey. The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services assist in the dissemination of information on trauma.

If multiple injuries have occurred to the same hand, the "lost" index finger may serve as a source of valuable building blocks for restoring the rest of the hand. Nothing should be discarded that can serve to reconstruct the other injured fingers.[1] Skin flaps can be used as island pedicle or flaps for coverage while phalanges may serve well as bone grafts. Tendons may be transferred or grafted as the needs dictate and even nerve segments used for grafts if gaps are present in other fingers.

Although any other finger may be just as valuable a source of tissue, the propensity of the index finger to injury and its expendability makes it more important in this regard. Obviously when reconstruction is reasonable or imperative it is most appropriate to carry out whatever procedures are needed to serve this end. Overall useful function and morbidity must be considered in any plans that recommend reconstruction of the injured hand and digits.

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A teaching program in primary care

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There is limited access to high quality comprehensive health care throughout the nation. Disadvantaged inner city residents are particularly affected by the lack of such care. The shortage of providers and a financial barrier contribute to failure in the delivery of comprehensive care. In 1970, the Philadelphia Model Cities program contracted with Episcopal Hospital to provide comprehensive ambulatory health care at no charge to families residing in a defined geographical target area. This agreement has resulted in the formation of a hospital based group practice which unites the skills of community health workers, nurse practitioners, and other allied health personnel with those of the physicians in the provision of comprehensive care.

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Since its inception, this model for delivering cost effective, high quality, ambulatory health services has continued to evolve. The techniques utilized in this program make efficient use of the physician's time, permitting an increased patient-physician ratio. The expected use of these methods and our ability to influence today's medical and nursing students to practice in an area of need, will affect access to health care in the future. The following discussion focuses upon medical student involvement in the delivery of comprehensive ambulatory care.

Content

The teaching affiliation between Episcopal Hospital and Temple University School of Medicine set the foundation for inducing students to become providers of primary care in this urban community. In addition, this teaching program has had participants from eight other medical schools and three local nursing schools. As a consequence of Temple's affiliation, a significant portion of Temple's medical students receive clinical training at Episcopal Hospital. An HEW grant to encourage students to enter careers in primary care (internal medicine, pediatrics and family practice) has further benefitted the teaching endeavors.

An address to the freshman class during their orientation week has provided an opportunity to introduce incoming students to the activities and objectives of Episcopal's comprehensive care program. As a result, several first and second year students have applied for a fellowship in community medicine offered during the recess between the first and second or second and third years. These students enjoy working with a physician in primary care and seeing the correlation between their recent basic science education and their future roles as clinicians. Each student has been assigned to spend a half day, the same one each week, with one of five internists, two half days observing and assisting in both pediatrics and OB/GYN, and a portion of another day making home visits with a community health worker. A weekly journal club provides a forum for discussions of a variety of

topics such as death and dying, national health insurance, prepaid vs. fee for service systems for financing health care, psychosurgery, drug abuse, and other behavioral problems affecting health.

Throughout the year, one-third of Temple's junior class comes to Episcopal Hospital in groups of eight for six weeks of medicine. Several half day sessions are spent in the Comprehensive Health Center learning to manage the health problems of ambulatory adults. An opportunity is thereby given to the junior students to evaluate and follow the same few patients with careful guidance by our staff. It is our observation that students early in their third year need assistance in collecting the data necessary to make an evaluation, in addition to receiving considerable direction in the management of detected problems. As a result of their exposure to ambulatory medicine in this manner some of the juniors elect to join us in their senior year.

Senior students in a six week elective learn to deliver comprehensive ambulatory care in the role of a primary physician. They perform the initial comprehensive examination of adults, develop a diagnostic and therapeutic plan for the management of their patients' problems, and present their data and plan in a problem-oriented fashion, to one of the staff internists for review. The faculty supervisor reviews the history and physical findings and suggests alternative and additional planning and management techniques when necessary.

Senior students in the elective program are encouraged to spend up to 30 percent of their time in activities other than adult primary care. Specific time allotments, e.g., three half days per week for three weeks, may be spent in the same health center with a specialist in ENT, ophthalmology, dermatology, rheumatology or neurology. Alternatively, the student may select time in pediatrics and OB/GYN. Students planning to follow a primary care path in an urban or suburban setting are encouraged to pursue exposure to several medical specialities. Those interested in rural primary care are advised to take the pediatric-OB/GYN alternative. This recommendation represents our perception of training appropriate to the health care delivery system in these respective geographical areas.

An occasional student may find the opportunity to launch a project to evaluate the community's health resources for dealing with specific problems. One student, for example, arranged the coordination of a hospital alcoholics anonymous (AA) program to help support such patients. Two others researched modes of drug abuse treatment available in the community and have solidified our connections with various treatment programs. Another student worked in conjunction with the psychiatrists in our associated Community Mental Health Program and developed the mental health questionnaire portion of our Health Assessment Questionnaire.

The skills we expect students to develop are outlined as follows:

1. History taking:
   a. learn how to utilize paramedics to obtain part of the history
   b. learn how and when to take brief and directed histories
   c. know how to take a full and comprehensive history, including dividing this exercise over more than one session.
2. Physical examination
   a. be capable of a full and reliable physical examination
   b. have judgment concerning when to defer or omit one or more parts of the examination.
3. Problem identification
   a. know what laboratory studies could help identify the problem
   b. show judgment in selecting the studies—which should be ordered at the first visit, which have the highest likelihood of helping, and which can be deferred; have some idea of costs of studies
   c. recognize health related problems—physical, psychological, economic, or demographic
   d. learn the common causes of morbidity and mortality for the population served
4. Problem solving
   a. know when a referral is in order, how to make a successful referral, and how to select a sound consultant
   b. know when hospitalization is indicated
5. Management in addition to the basic curriculum
   a. recognize the impact of social, economic, cultural, and psychological factors upon the patient's motivation to cooperate in his care
   b. appreciate that a given personal approach affects patients differently and that the approach must be modified for the individual patient
   c. provide continuity of care—the avoidance of mere episodic care, the appreciation of the impact of chronic disease, the appreciation of the need for anticipatory guidance and patient education, for example, the expected side effect of a medication
   d. an understanding of the factors that determine the frequency of follow-up visits
   e. a recognition of the need for a plan for comprehensive care even if achieved over a long time
6. Communicate clearly and effectively with the patient, for example, when and how to present the problem of malignancy to the patient and the family
7. Manage the "well" hypochondriacal or manipulating patient
   a. what are the basic issues?
   b. what is realistic care?
   c. when is referral to nonphysician professionals in order?
   d. what is the role of hospitalization?
   e. what are patient's mechanisms of gain and manipulation?

We endeavor to teach students to control the cost of health care in the process of *solving problems* by limiting laboratory tests ordered at one visit and by making an evalua-

tion of the patient's problem by a logical sequence of studies. We have developed several protocols which are intended to assist the students in this regard while standardizing a high level of quality in the management of common illnesses. We demonstrate to the student that the cost of care is reduced by prescribing generically available medications and by delegating more responsibilities to nonphysicians in order to effect optimal utilization of physicians' time.

Students experience the fact that continuing care is a means to an optimal state of health. Continuing care provides an appreciation of the nature of chronic illness, which balances the current disproportionate exposure to acute illness in most medical school curricula. Continuing care permits the application of a preventive medicine plan which can be offered by the team of primary care providers.

Concluding comments

The great need for additional providers of primary health care—internists, pediatricians, and family practitioners—justifies a modification in present day medical school curricula. One method of achieving this objective is to require all medical students to select at least one of several experiences in primary care in their senior year.

Among the multiple potential sites for a primary care experience, this setting has distinct advantages. A hospital based group practice affords immediate access to various specialists for consultations, including service departments such as radiology, pathology, and nuclear medicine. In addition, it is convenient for the continuous care of hospitalized patients.

A primary care experience is relevant regardless of the student's ultimate career choice. If a specialist is to be optimally effective, he should be familiar with the potentials and limitations (including socioeconomic) of primary care. Until physicians accomplish a maximum amount of care on an ambulatory basis, relatively expensive overutilization of hospitals will continue as a means of solving problems.

Summary

Various techniques are utilized in a program designed to develop future primary physicians. These include: (1) observation of the doctor-patient encounter, (2) family study by means of home visits which shed light on the constellation of socioeconomic circumstances affecting health, and (3) functioning under supervision in the role of a primary physician. Health care management problems range in complexity from episodic illness in a young person to an elderly patient with multiple chronic health problems coexisting with socioeconomic barriers to their solution. Students should assume responsibility for less complicated cases initially and gradually take on more difficult patients. A team of health care providers demonstrate to students a cost effective approach to providing high quality comprehensive care in this setting.

In addition to imparting the attitudes and techniques prerequisite for effective comprehensive ambulatory care, a major objective of our program is to show that such health services can be delivered to a disadvantaged community in a desirable atmosphere. Physicians can derive tremendous satisfaction from both the service to patients with great needs and the intellectual stimulation of teaching. □

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Colonoscopy and polypectomy

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Early colonoscopes had several drawbacks. A prototype, made available to us for evaluation in 1968, was long enough to examine the sigmoid colon and was a clumsy instrument. It had no mechanism for maneuvering the tip and produced considerable mucosal damage. Examinations were uncomfortable for all patients and painful for most. The optical system was poor and fibers fractured after only 25-30 examinations.

Improvements have, however, developed quickly. Newer models are ingenious and have created extensive interest. Many reports have been enthusiastic in advocating the clinical value of colonoscopy in diverse circumstances. It permits early and precise diagnosis of disease throughout the colon, clarifies equivocal findings noted on barium studies and at times demonstrates lesions not otherwise evident. Perhaps the most enthusiastic response has been brought about by the ability to use the colonoscope for cautery snare resection of colonic polyps but there is some concern that this initial fervor may be precipitate. Anxiety has been expressed concerning the safety of the procedure and there is a supposition communications have not been sufficiently candid. The possibility of overutilization has also been intimated. This new ability to remove polyps without laparotomy has not, therefore, solved the annoying problem concerning their proper management. "Theoretically, this amounts to removal of polyps in 1 of every 2 patients who are sixty years or older with possible iatrogenic risks or complications far in excess of the risk of cancer."[1] Further: "Colonoscopy is not always innocuous and is sometimes technically difficult. Also, it is not necessary to remove every tiny polyp in the bowel,"[2] and, "In fact, in one of the largest private hospitals in Washington, D.C., colonoscopy is prohibited as a dangerous unproven procedure."[3]

It would be profitless to attempt resolution of this difference of opinion concerning the advisability of "routine" polypectomy. Certainly no one really believes every colon polyp must be removed but it is apparent more polypectomies are being performed since laparotomy is no longer necessary. We would agree in the absence of bleeding, other symptoms, or a suspicion of cancer, some of these procedures may be meddlesome, but we do not believe they need be associated with excessive complications. Certainly the safety of an operation alone is not sufficient reason for doing it. We would like to stress that colonoscopy with polypectomy can be performed anywhere in the colon with remarkably few complications *but does require prudence and experience.*

Methods and equipment

Bowel preparation—Preparation of the colon has varied. Our preference at present is a 48 hour regimen. This consists of a diet restricted to liquids, clear liquids only the day prior to the procedure, castor oil and cleansing tap water enemas. An antibiotic bowel preparation for patients scheduled for polypectomy has been discontinued.

TABLE I
Colonoscopy Procedures

Procedure	*Number*
Colonoscopies	659*
(Diagnostic only)	(478)
Patients having polypectomy	181
Polypectomies	204
(Pedunculated)	(196)
(Sessile)	(8)

* *Total number of patients—587. Some patients had more than one procedure.*

Other considerations—Coagulation profiles are obtained routinely on all patients. Apprehensive patients are given 5-10 mg of diazepam intramuscularly. This may be supplemented with 50-75 mg of meperidine, also intramuscularly This has been satisfactory when given a little in advance of the procedure and avoids the hazards and requirements of intravenous administration.

General anesthesia has not been used. It is not necessary and may

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be inadvisable. Anticholinergics have been given at times to minimize peristalsis. If the patient is not already hospitalized, diagnostic colonoscopy is usually performed on an ambulatory basis. Some of the polypectomies have also been done on outpatients. Geographic

TABLE II
Location of Polyps

Location—Colon	*Number*
Distal Sigmoid	24
Proximal Sigmoid	101
Descending	63
Transverse	12
Ascending	3
Cecum	1
Total	204

and other considerations sometimes preclude ambulatory treatment.

Our experience has been with Olympus equipment—CF Special (105 cm), CF-MB (105 cm), and CF-LB (180 cm). Prior to the availability of commercial snares it was customary to fashion a "homemade" model. An insulating sheath was obtained by salvaging the tubing from an Olympus washing tube. Through this was threaded a loop of stainless steel cable with an OD of .024 inches. We have become accustomed to this type snare and prefer it to the commercial models which are relatively expensive. Recently, however, there has become available a reasonably priced commercial model which is similar to the type we have described. A reliable electrocoagulating unit is essential, preferably one with an output isolated from ground.

We have not insufflated with inert gases during polypectomy and believe the possibility of explosion in a properly cleaned colon has been exaggerated.

Clinical material—From March 1972 through May 1974 204 colon polyps (in 181 patients) beyond reach of the standard rigid sigmoidoscope have been removed endoscopically through the colonoscope. (Table I) The anatomic distribution of these polyps is given in Table II. Multiple polyps were removed in one or more sessions. (Table III)

There have been remarkably few complications associated with these polypectomies. Delayed bleeding occurred in two patients—on the tenth and fourteenth day after polypectomy. The amount of blood loss was minimal. One patient estimated it to be "about a tablespoonful;" the other described a streak of bright red blood staining one bowel movement.

Large polyps cause a special technical problem with a potential for serious complications. It is sometimes not possible to maneuver these polyps into a position which clears all sides of the colon wall. Should the polyp head be in contact with an opposite wall throughout the period of electrocoagulation, a dangerously deep burn may occur. Under these circumstances laparotomy with colotomy is the safer method for polypectomy. In several of the patients being reported superficial injury was produced from brief periods of contact. There have been no perforations or explosions.

TABLE III
Polyps/Patient

Number of Polyps	*Number of Patients*	*Total Number of Polyps*
1	163	163
2	14	28
3	3	9
4	1	4
—	181	204

The specimens ranged from 0.5 cm to 4.6 cm in diameter. Histologic features are summarized in Table IV. The three specimens classified "polypoid adenocarcinoma" were small sessile lesions about 1 cm in diameter and remarkably similar in gross appearance. Histologic features were typical of colon adenocarcinoma and the line of transection cut across the tumor. Each of these patients underwent a colon resection several days after polypectomy. The operative findings and examination of the surgical specimen were interesting. The site of recent polypectomy was easily identified. In two patients there was no evidence of residual local disease or nodal metastases. These small cancers apparently were superficial and destroyed by the coagulating current. The third patient presented an unusual situation. Again there was no evidence of residual local cancer at the polypectomy site (a stage A lesion, applying Dukes classification to the colon) but there was extensive regional and para-aortic nodal metastasis.

TABLE IV
Histologic Features

Type	*Number*
Adenomatous polyp	161
(with focal carcinoma)	(9)
Villous adenoma	38*
(with focal carcinoma)	(6)
Unretrieved	2
Polypoid adenocarcinoma	3
	204

* *Three of these were classified "villoglandular."*

Polypectomy is considered adequate treatment for those patients with focal carcinoma in a peduncular polyp. During the rather short period included in this report there has been no evidence of local recurrence or clinical findings to suggest metastatic disease in 15 patients with focal carcinoma.

Colonoscopy serves one of its most useful functions when there is rectal bleeding and a normal barium enema. In this group, eleven patients with rectal bleeding suspected to be colonic in origin and who had one or more "negative" barium studies were found to have colonic polyps. Conversely six patients with barium enemas demonstrating a "polyp" did not have a polyp on colonoscopy and repeat barium studies confirmed the colonoscopic findings.

Colonoscopy is not suited and should not be considered a substitute for the barium enema but when roentgen findings are inconclusive and/or not in accord with clinical findings, colonoscopy is of proven value. Colonoscopic polypectomy in experienced hands should be associated with little risk, but obviously there is potential for serious complications and eventually some will occur. □

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3. **Smith, L. E.; Nivatvongs, S.** Personal communication. Nat. Nav. Med Center. March 1, 1974.

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obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Charles Sylvester Cain**, Pittsburgh; Temple University School of Medicine, 1926; age 73; died April 29, 1975. He is survived by his wife, a son, four daughters, and a sister.

• **Montano D. Debuque**, Quakertown; Manila Central University, 1954; age 45; died May 16, 1975. He is survived by his wife, mother, two daughters, and four sons.

• **William Paul Dodds**, Harrisburg; Columbia University College of Physicians and Surgeons, 1917; age 86; died April 3, 1975. Information regarding survivors is unavailable.

• **Arthur Samuel Fox**, Bethlehem; Maryland Medical College, 1910; age 92; died April 21, 1975. Surviving are a daughter and a son.

• **Samuel C. Gomory**, Pittsburgh; University of Budapest, 1919; age 81; died April 29, 1975. His wife and a daughter survive him.

• **Robert Armand Groff**, Philadelphia; University of Pennsylvania School of Medicine, 1928; age 71; died April 25, 1975. He was certified by the American Board of Psychiatry and Neurology and the American Board of Neurosurgery. He was professor and chairman of the department of neurosurgery at the Hospital of the University of Pennsylvania from 1957 to 1968 and published over 50 articles in his field. His wife and a sister survive him.

• **Bernard Joseph Hackett**, Brownsville; University of Pittsburgh School of Medicine, 1930; age 71; died May 16, 1975. His wife and a sister survive him.

• **John Malcolm Hollingsworth**, Erie; University of Pittsburgh School of Medicine, 1937; age 62; died May 19, 1975. In 1969 he was named citizen of the year by the Girard chamber of commerce. His record of delivering 3,000 babies without losing a mother was noted in JAMA. His wife, two sons, one daughter, and two stepdaughters survive him.

• **Louis W. Jones**, Harveys Lake; University of Pittsburgh School of Medicine, 1924; age 74; died May 23, 1975. He was past president of the Luzerne County Medical Society in 1950 and president of the State Society in 1951. He served on a number of committees and was a delegate to the AMA. He was a member of the Philadelphia Orthopaedic Society, Pennsylvania Orthopaedic Society, American Academy of Orthopaedic Surgeons, and the American College of Surgeons. He is survived by his wife, a son, and a daughter.

• **John A. Krosnoff**, Bentleyville; Maryland Medical College, 1923; age 72; died April 23, 1975. Surviving are three sons, one of whom is John A. Krosnoff, Jr., M.D.

• **James D. Maxwell**, Greensburg; University of Pennsylvania School of Medicine, 1940; age 61; died May 1, 1975. He was past president of the Southwestern Pennsylvania Chapter of the American College of Surgeons and the Pittsburgh Surgical Society, a diplomate of the American Board of Surgery, and a fellow of the American College of Surgeons. He taught the original first aid course for ambulance drivers and attendants and his material has been incorporated in the state's first aid manual. His wife, four children, two sisters, and a brother survive him.

• **Paul G. McKelvey, Sr.**, Greensburg; University of Pennsylvania School of Medicine, 1924; age 78; died April 27, 1975. Surviving are one daughter, two sons, one of whom is Paul G. McKelvey, Jr., M.D., and one brother.

•**Lawrence Victor Perlman**, Pittsburgh, Yale University School of Medicine, 1961; age 39; died May 17, 1975. He was associate professor at the University of Pittsburgh School of Medicine. He was a fellow of the American College of Physicians and American College of Chest Physicians and certified in internal medicine and family practice. He was a member of the American Public Health Association and the American Federation on Clinical Research. His wife and three children survive him.

• **Herman Louis Rudolph**, Reading; Jefferson Medical College, 1935; age 66; died April 29, 1975. He was past president and vice president of the American Academy of Physical Medicine and Rehabilitation. In 1947 he was appointed civilian consultant in physical medicine to the Surgeon General of the U.S. Army. In 1965 he was chosen Pennsylvania Physician of the Year. He was chief of the department of physical medicine and rehabilitation at Community General Hospital. Information regarding survivors is unavailable.

• **Herbert Salis**, Philadelphia; University of Pennsylvania School of Medicine, 1943; age 58; died April 2, 1975. His wife, four children, and two brothers survive him.

• **William Anthony Tomasco**, Philadelphia; Hahnemann Medical College, 1936; age 66; died March 24, 1975. He was a fellow of the Industrial Medical Association and a member of the regional committee on trauma of the American College of Surgeons. He is survived by his wife, a son, a daughter, a brother, and three sisters.

• **Carl G. Vonderheid**, New Kensington; University of Pittsburgh School of Medicine, 1934; age 66; died May 13, 1975. He was head of the dermatology department at the Veterans Administration Hospital in Pittsburgh. He is survived by his wife, a daughter, a son, and two sisters.

• **Charles R. Yhost**, Clearwater, Florida; Hahnemann Medical College, 1927; age 74; died April 19, 1975. His wife and four brothers survive him.

Edwin Stephen Peters, Masontown; Northwestern University Medical School, Chicago, Illinois, 1940; age 60; died April 8, 1975. Surviving are his wife, three children, and five brothers and sisters including Jerome F. Peters, M.D., Robert J. Peters, M.D., and Richard C. Peters, M.D.

Articles of Incorporation of Pennsylvania Medical Cooperative

These are the final Articles of Incorporation and By-laws of the Pennsylvania Medical Cooperative as approved by the Pennsylvania Medical Society Board of Trustees and Councilors. The Cooperative is expected to be operational late this summer.

WE, THE UNDERSIGNED, being natural persons of the age of 21 years or more and citizens of the United States and members in good standing of the Pennsylvania Medical Society, in order to form a nonprofit cooperative under and pursuant to the provisions of the "District of Columbia Cooperative Association Act," June 19, 1940, ch. 397, and all acts amendatory thereof and supplemental thereto, do hereby certify as follows:

ARTICLE I

The name of the Cooperative is Pennsylvania Medical Cooperative.

ARTICLE II

The purpose for which the Cooperative is formed is the facilitation in the purchase of supplies and services for physicians and to do and perform, either for itself or as agent for its members, any and all acts and things, and to have and exercise any and all powers, as may be necessary or convenient to accomplish any or all of the foregoing, as may be permitted by the Act under which the Cooperative is formed, in this State and in any other State.

ARTICLE III

The Cooperative shall have perpetual existence.

ARTICLE IV

The location of the principal office of the Cooperative is 20 Erford Road, Lemoyne, Commonwealth of Pennsylvania.

ARTICLE V

Section 1. The Cooperative is formed not for profit and is organized without shares. Each member shall be limited to one (1) membership interest which shall constitute the maximum amount of capital which may be controlled or owned by any one member. The number of initial memberships subscribed for is 1820. Property rights of members shall be proportionate to the amount

of each respective member's patronage of the Cooperative.

Section 2. The undersigned incorporators shall be members of the Cooperative. In addition to the undersigned incorporators, any person, firm, or corporation otherwise qualified under the District of Columbia Cooperative Association Act and the By-laws of the Cooperative may become a member of the Cooperative by: (a) acquiring a membership interest in the Cooperative, as shall be specified in the By-laws of the Cooperative; and (b) agreeing to comply with and be bound by the terms and conditions relating to membership contained in these Articles of Incorporation and the By-laws of the Cooperative and any amendments thereto, provided, however, that no applicant for membership shall become a member of the Cooperative unless and until the applicant has been accepted for membership by the members or by the Board of Directors or by its duly authorized representative.

Section 3. Each member in good standing shall be entitled to one (1) vote and no more upon any single subject, which vote shall be cast in person and not by proxy.

Section 4. The By-laws of the Cooperative may define and fix the duties and responsibilities of the members and prescribe such other terms and conditions upon which members shall be admitted to and retain membership in the Cooperative, not inconsistent with these Articles of Incorporation or the Act under which the Cooperative is organized.

ARTICLE VI

Section 1. The net savings of the Cooperative shall not be used to pay dividends to members on their membership interests except that payments not in excess of six per centum (6%) upon the paid-up capital may be made thereon and shall be noncumulative. Receipts shall be used in the manner to be provided in the By-laws, which shall be consistent with these Articles of Incorporation and the Act under which the Cooperative is organized.

Section 2. No member shall be liable for any debts or obligations of the Cooperative; nor shall any member be liable for any assessment.

Section 3. Upon dissolution of the Cooperative, any surplus shall be distributed among those patrons who have been members or subscribers at any time during the past six years, on the basis of their patronage during that period, in accordance with § 36 of the "District of Columbia Cooperative Association Act," June 19, 1940, ch. 397, and all acts amendatory thereof and supplemental thereto.

ARTICLE VII

Section 1. The Directors of the Cooperative shall be elected by and from the members of the Cooperative. The number of directors shall be fixed from time to time by the By-laws of the Cooperative. The names and addresses of the directors who shall manage the affairs of the association for the first year, unless sooner changed by the members, in accordance with the By-laws, are: Kenneth L. Cooper, M.D., 230 Dunbar Rd., Williamsport; H. Robert Davis, M.D., 112 4th St., Boiling Springs; James B. Donaldson, M.D., 3401 N. Broad St., Phila.; Leo C. Eddinger, M.D., 951 N. 4th St., Allentown; Lawrence D. Ellis, M.D., 3515 5th Ave., Pittsburgh; David F. Gillum, M.D., 114 East Ave., Wellsboro; Richard L. Huber, M.D., 1736 Sanderson Ave., Scranton; Thaddeus Lekawa, M.D., 2801 N. George St., York; Robert N. Moyers, M.D., 764 Kennedy St., Meadville; Robert Poole, M.D., 419 N. Franklin, W. Chester; John F. Rineman, 20 Erford Road, Lemoyne; George A. Rowland, M.D., 101 State St., Millville; and Ulysses E. Watson, M.D., Henry Ave. & Abbottsford Rd., Philadelphia.

Section 2. The members of the Cooperative shall have the power to make, amend, or repeal the By-laws of the Cooperative.

IN WITNESS WHEREOF, we, the undersigned incorporators, have hereunto set our names and addresses and affixed our seals, this 19th day of April, 1975.

Ulysses E. Watson, M.D.
Henry Avenue & Abbottsford Rd.
Philadelphia, Pa.

Lawrence D. Ellis, M.D.
3515 5th Ave., Pittsburgh, Pa.

Richard L. Huber, M.D.
1736 Sanderson Ave., Scranton, Pa.

Leo C. Eddinger, M.D.
951 N. 4th St., Allentown, Pa.

Robert Poole, M.D.
419 N. Franklin, West Chester, Pa.

H. Robert Davis, M.D.
112 4th St., Boiling Springs, Pa.

Robert N. Moyers, M.D.
764 Kennedy St., Meadville, Pa.

John F. Rineman
20 Erford Road, Lemoyne, Pa.

STATE OF PENNSYLVANIA:
SS.
COUNTY CUMBERLAND:

On this 19th day of April, 1975, before me Jean B. Hain, a Notary Public in and for said State, personally appeared H. Robert Davis, M.D., Robert N. Moyers, M.D., and John F. Rineman, known to me to be the persons whose names are subscribed to the within instrument and acknowledged to me that they executed the same.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal the day and year first above written.

Jean B. Hain
Notary Public

My Commission Expires:
June 22, 1975.

Pennsylvania Medical Cooperative By-Laws

The object of the Pennsylvania Medical Cooperative is to aid physicians in the purchase of supplies and services.

Article I. Offices

Section 1. Principal Office. The principal office of the Cooperative shall be located at 20 Erford Road, Lemoyne, Commonwealth of Pennsylvania.

Section 2. Other Offices. The Cooperative may also have offices at such other places as the Board of Directors, from time to time, may designate.

Article II. Membership

Section 1. Eligibility. Persons otherwise qualified under the Articles of Incorporation who are members in good standing of the Pennsylvania Medical Society residing or practicing within Pennsylvania and the Executive Vice-President of the Pennsylvania Medical Society.

Section 2. Application for Membership. A person who is not one of the incorporators, in order to be admitted to membership, shall file with the Cooperative an *application for membership* in such form as shall be provided by the Board of Directors. The application form shall include, in addition to such information as the Board of Directors may determine, a statement that the applicant agrees to (1) comply with and be bound by the terms and conditions relating to membership contained in the Articles of Incorporation and in these By-laws and amendments thereto; and (2) acquire a membership interest in the Cooperative.

Section 3. Members. The members shall consist of the incorporators and such applicants as have been approved by the members or by the Board of Directors or by its duly authorized representative. An applicant for membership may be approved if it is believed that the acceptance of the application will be for the mutual benefit of the members and consistent with the accomplishment of the corporate purposes.

Section 4. Transfer of Membership Interest. The membership interest shall not be transferrable. No person shall become a member unless an application for membership is filed in accordance with Section 2 of this Article and is approved as therein provided.

Section 5. Expulsion. The Board of Directors may expel any member of the Cooperative at any duly convened meeting for failure to comply with the By-laws or with any rules or regulations of the Cooperative provided that ten (10) days notice has been given to the member in writing indicating the intention to cause the expulsion and the specific reason therefor and provided that the member is given an opportunity to appear and be heard in person or by counsel. An appeal from the action of the Board can be taken by filing, within twenty (20) days after the action, a petition, signed and sworn to by the member, with the Secretary of the Cooperative, which petition is to be acted upon by the members at the next meeting after the petition is filed. In the event of expulsion, the Board of Directors shall purchase the member's certificate by paying him the original cost of such certificate along with any funds accumulated in his account in accordance with Article VII, Section 2 of these By-laws, less any indebtedness owing to the Cooperative by the member, if and *when there is sufficient reserve funds,* and the member shall no longer be entitled to the rights, privileges, and benefits of membership.

Section 6. Limited Liability of Members. Members shall not be liable for any debts or obligations of the Cooperative and shall not be subjected to any assessment.

Section 7. Withdrawal from Membership. A member may withdraw from membership at any time he sees fit, and the Director shall purchase his membership certificate by paying him an amount determined in the manner described in Section 5 of this Article.

Section 8. Death of a Member. In the event of the death of a member, the Cooperative shall purchase his membership certificate by paying his estate an amount determined in the manner described in Section 5 of this Article.

Section 9. Automatic Cessation of Membership. In the event a member no longer meets the membership requirements set forth in the By-laws and Articles of Incorporation or is expelled or withdraws from membership in the Pennsylvania Medical Society, membership in this Cooperative ceases and the Cooperative shall purchase his membership certificate by paying him an amount determined in the manner described in Section 5 of this Article.

Article III. Meetings of Members

Section 1. Place of Meetings. All meetings of members shall be held at the principal office of the Cooperative or at such other place as the Board of Directors, from time to time, may determine.

Section 2. Annual Meetings. An annual meeting of members shall be held on the last day of March of each year at 10 o'clock A.M., E.S.T., if not a legal holiday, or if a legal holiday, on the next business day following.

Section 3. Special Meetings. A special meeting of the members may be called at any time by the President and must be called by him when so directed by a resolution of a majority of the Board of Directors or by a written request signed by at least ten per centum (10%) of the members of the Cooperative, provided that the resolution or request specifies the purposes of the special meeting. No business may be transacted at any special meeting unless such business was specified in the notice for such meeting. Business that should have been transacted at a regular meeting may be transacted at an ensuing special meeting, if such business was specified in the notice of the special meeting.

Section 4. Notice of Meeting. Notice of all meetings and of any unusually important business to be transacted at the meeting shall be mailed or delivered not

less than two (2) weeks before such meetings, and, in the case of a special meeting, the purpose or purposes shall always be specified in the notice.

Section 5. Quorum. A majority of the members present in person shall constitute a quorum at any meeting, but the members present at a duly organized meeting may continue to do business until adjournment notwithstanding the withdrawal of enough members to leave less than a quorum.

Section 6. Adjournments. Adjournment or adjournments of any organized or unorganized annual or special meeting of members may be taken. Upon such adjournment, it shall not be necessary to give any notice of the adjourned meeting or of the normal business to be transacted other than by announcement at the meeting at which such adjournment is taken.

Section 7. Order of Business. The order of business at regular meetings and, insofar as possible, at other meetings of the members shall be as follows:

(1) recording of the members present by the number thereof or by their names;

(2) reading of notice of meeting;

(3) reading and action on the record of all proceedings and of all meetings that remain unapproved;

(4) reports of the Board of Directors and of Officers and committees;

(5) presentation of profit and loss statement and balance sheet, audited at the end of each fiscal year by an experienced bookkeeper or accountant, who shall not be an officer or a director. Where the annual business is less than $10,000, the audit may be performed by an auditing committee consisting of three (3) persons who are not directors, officers, or employees and who are elected by and from the members;

(6) elections;

(7) unfinished business;

(8) new business; and

(9) adjournment.

Section 8. Voting. A member shall be entitled to only one vote upon any single subject, which vote shall be cast in person and not by proxy. At any meeting of members, all elections and questions shall be determined, except as is specifically provided otherwise by law or by these By-laws, by the votes of a majority of the members present in person. No member shall be permitted to vote at any meeting of the Cooperative if he owes to the Cooperative any obligation that is past due and if he has been sent notice that he will not be permitted to vote until his past due obligation is paid.

Section 9. Elections. At all elections, nominations shall be made from the floor. Unless there is no contest, the voting shall be by closed ballot.

Article IV. Board of Directors

Section 1. Number. The affairs of the Cooperative shall be managed by a Board of Directors consisting of thirteen (13) persons elected by and from the members of the Cooperative, two of which are members of the Board of Trustees of the Pennsylvania Medical Society and the Executive Vice-President of the Pennsylvania Medical Society.

Section 2. Term of Office. The Board of Directors elected at the first meeting of the members of the Cooperative shall hold office until their successors assume office. The first Board of Directors shall decide by lot or otherwise, as they may deem best, who shall constitute the five (5) directors whose terms of office are to end at the next election at the annual meeting of members. Thereafter four (4) directors are to be elected at one annual meeting, and four (4) directors are to be elected at the next annual meeting, and each director shall be elected for a term of two (2) years and until his successor is elected and assumes office. A director shall be eligible for reelection at the expiration of the term of his office.

Section 3. Removal of Directors. Any director may be removed from office with or without cause by a vote of not less than seventy-five per centum (75%) of the members of the Cooperative present at any meeting, the notice for which includes such purpose. If a director is removed, the members may at the same meeting fill the vacancy.

Section 4. Vacancies. In the event of any vacancy in the Board of Directors through death, resignation, or other cause, but not if a director has been removed or if the number of directors has been increased, the remaining directors may by a majority vote, elect a successor to hold office until the next meeting, at which time a director shall be elected to complete the term of the director whose place was vacant.

Section 5. Compensation. No compensation shall be paid to directors other than expenses as determined by the Board. A director shall not be entitled to any remuneration for services performed by him in any capacity for the Cooperative unless a resolution authorizing payment for such services has been adopted before the services began.

Section 6. Duties of the Board. The duties and powers of the Board of Directors, in addition to those imposed elsewhere in the By-laws, and in addition to those necessary or appropriate for the proper conduct of the affairs of the Cooperative, shall be as follows:

(a) to manage the affairs of the Cooperative to include the manner in which the receipts of the Cooperative will be disposed in accordance with Article VII, herein, and to make all proper rules and regulations in connection therewith;

(b) to borrow money for the Cooperative and to make, execute, and issue mortgages, bonds, deeds of trust, trust agreements, and any negotiable or other instruments and securities secured by mortgage or otherwise;

(c) to enter into such contracts as may help effectuate the purposes of the Cooperative;

(d) to appoint committees composed of members and to delegate to them any duties that are required to be executed and to require such committees to report to the Board of Directors or to the members;

(e) to make such reports at the annual meetings as are necessary to disclose in detail the financial condition of the Cooperative, the compensation of directors, officers, and employees, and the status of the affairs of

the Cooperative; and

(f) to consider and pass upon applications for membership or to authorize an officer or representative of the Cooperative to consider and pass upon applications for membership.

Section 7. Executive Committee. The Board of Directors, by resolution adopted by a majority of the Directors in office, may designate and appoint an Executive Committee, which, to the extent provided in said resolution, shall have and exercise the authority of the Board of Directors in the management of the Cooperative. The Executive Committee designated hereunder shall have no power or authority with regard to amending the Articles of Incorporation, adopting an Agreement of Merger or Consolidation, recommending to the members the sale, lease or exchange of all or substantially all of the corporation's property and assets, recommending to the members a dissolution of the Cooperative or a revocation of a dissolution or amending the By-laws of the Cooperative.

Article V. Meetings of Board of Directors

Section 1. Place of Meetings. All meetings of the Board of Directors shall be held at the principal office or at such other place as the Board of Directors, from time to time, may determine.

Section 2. Regular Meetings. Regular meetings of the Board of Directors shall be held immediately after the annual meeting of members and once a month thereafter, at such time and date as may be fixed by the directors for regular meetings.

Section 3. Special Meetings. Special meetings of the Board of Directors may be called at any time by the President or by three (3) directors.

Section 4. Notice. No notice shall be required for regular meetings of the Board of Directors, but for special meetings notice shall be mailed or delivered not less than five (5) days before the meeting, and the notice shall state the purpose of the meeting, and no other business shall be transacted except with the unanimous consent of all the directors holding office.

Section 5. Quorum. A majority of all the directors elected shall constitute a quorum for the transaction of business at any meeting.

Section 6. Official Acts of the Board. Each of the official acts of the Board of Directors shall be by a majority vote of the directors present and shall be recorded with the yeas and nays of each director or the unanimous approval thereon in the minute book of the Cooperative.

Article VI. Officers and Employees

Section 1. Election of Officers. The Board of Directors shall elect a President, Vice-President, Secretary, Treasurer, and Assistant Secretary-Treasurer, all of whom shall be members of the Cooperative. The President and Vice-President shall be directors. The remaining officers, if not members of the Board of Directors, may participate in meetings of the Board without the power to vote at such meetings.

Section 2. Duties of President and Vice-President. The President shall preside at all meetings of members or of directors. He shall rule on all questions and points of order that may arise during the course of meetings and shall not vote at meetings of the members unless there is a tie. Except as otherwise provided by resolution, he shall sign or countersign all certificates issued to members and all contracts and other official instruments or documents of the Cooperative. In the absence of the President, or in the event of his inability or refusal to act, the Vice-President shall act in his stead.

Section 3. Duties of Secretary. The Secretary shall send notices of all meetings and keep minutes thereof. He shall have charge of the seal, membership books, papers, documents, and other records belonging to, or in the possession of the Cooperative.

Section 4. Duties of Treasurer. The Treasurer shall have custody of all funds and securities of the Cooperative. He shall deposit in the name of the Cooperative all funds together with notes, checks, or similar instruments endorsed by him for collection in such place or places as the Board of Directors may designate. Receipts and vouchers for payments shall be signed by him. Except as otherwise provided by resolution, he shall sign all checks, notes, bonds or other evidences of indebtedness. He shall keep complete books of account and shall make monthly reports to the Board of Directors, showing in detail the financial condition of the Cooperative, including a list of all members indebted to it, the amount of their indebtedness, and the nature of their indebtedness. He shall pay obligations of the Cooperative when due and shall otherwise make disbursements under the discretion and approval of the Board of Directors. He shall, before entering upon the discharge of his duties, become bonded with a reasonable surety company, at the expense of the Cooperative, in such sum and form as the Board of Directors may require and approve.

Section 5. Duties of Assistant Secretary-Treasurer. In the absence of the Secretary or the Treasurer, or in the event of their inability or refusal to act, the Assistant Secretary-Treasurer shall act in their stead. He shall, before entering upon the discharge of his duties, become bonded with a reasonable surety company, at the expense of the Cooperative, in such sum and form as the Board of Directors may require and approve.

Section 6. Additional Duties. In addition to the duties herein enumerated, the officers shall perform such other duties as, from time to time, may be assigned to them by the Board of Directors.

Section 7. Removal of Officers. Any officer may be removed from office with or without cause by a vote of not less than seventy-five per centum (75%) of the Board of Directors present at any meeting, the notice for which shall include such purpose. If an officer is removed, the members may at the same meeting fill the vacancy.

Section 8. Manager. There shall be a manager who shall be selected by the Board of Directors. He shall have general supervision over the property and affairs of the Cooperative, subject always, however, to the direction, management, and control of the Board of

Directors. He shall make monthly written reports to the Board of Directors which shall set out in detail the general condition of the Cooperative. The manager shall further perform such other duties as, from time to time, may be assigned to him by the Board of Directors. He shall, before entering upon the discharge of his duties, become bonded with a responsible surety company, at the expense of the Cooperative, in such sum and form as the Board of Directors may require and approve.

Article VII. Disposition of Receipts

Section 1. Ascertainment of Net Savings. The receipts of the Cooperative during each year shall be first employed for the payment of all its operating expenses, including, without limitation, wages, salaries, taxes, maintenance, repairs, upkeep, replacement, insurance, and interest, and for the payment of any other obligations of the Cooperative as they become due. The balance shall be considered as the net savings of the Cooperative.

Section 2. Application of Net Savings. The net savings of the Cooperative, as determined in the manner set forth in Section 1 of this Article VII, shall be apportioned annually in the following manner: (1) Writing off preliminary expenses; (2) Not less than ten per centum (10%) shall be placed in a reserve fund until such time as the fund shall equal at least fifty per centum (50%) of the paid-up capital; and such fund may be used in the general conduct of the business. The amounts apportioned to the reserve fund shall be allocated on the books of the association on a patronage basis, or in lieu thereof, the books and records of the association shall afford a means for doing so, in order that upon dissolution or earlier, if deemed advisable, such reserves may be returned to the patrons who have contributed the same, subject to the limitations governing the methods and procedures for the dissolution of a Cooperative Association in the District of Columbia; (3) A return upon capital, not to exceed six per centum (6%), may be paid upon each membership certificate; but such return upon capital may be paid only out of the surplus of the aggregate of the assets over the aggregate of the liabilities (including in the latter the amount of capital) after deducting from such aggregate of the assets the amount by which such aggregate was increased by unrealized appreciation in value or revaluation of fixed assets; (4) A portion of the net savings, not to exceed five per centum (5%), shall be allocated for educational purposes; (5) The remainder shall be allocated at the same uniform rate to all members of the Cooperative in proportion to their individual patronage; (6) Notwithstanding the above, nothing in this Section shall prevent the Cooperative from disposing of the net savings from the rendering of services in such manner as to lower the fees charged for services or otherwise to further the common benefit of the members. In addition, nothing in this Section shall prevent an association from adopting a system whereby the payment of savings returns which would otherwise be distributed shall be deferred for a fixed period of months or years.

Article VIII. Membership Interests and Certificates

Section 1. Subscription of Membership: Payment of Subscription. Persons desiring to become members of the Cooperative shall complete the application procedure set forth in Article II, Section 2 of these By-laws and pay to the Cooperative a membership contribution as follows:

(a) With respect to persons making payment on or prior to January 31, 1975 - One Hundred Dollars ($100.00).

(b) With respect to persons making payment after January 31, 1975 - Two Hundred Dollars ($200.00).

Section 2. Form of Membership Certificate. Membership certificates shall be consecutively numbered and bound in one or more books and shall be issued in order therefrom; and on the stub thereof opposite each such certificate shall be entered the name and address of the owner, together with the date of issue, and each certificate shall be receipted for upon such stub or shall have affixed thereto a post-office receipt. The certificate shall exhibit the name of the holder and shall be signed by the President and by the Treasurer or Secretary. The certificate shall be sealed with the seal of the Cooperative, unless an engraved or printed facsimile thereof shall be represented thereon. Every such certificate, among other things, shall state that:

(a) No dividends or interest shall be payable upon the certificate except in the manner and limited amount as provided for in the By-laws;

(b) All members have the right to but one vote; and

(c) The Certificate is not transferrable.

Section 3. Issue of Certificates. Membership certificates shall be issued to each member only after they have been paid for in full.

Section 4. Lien on Certificates. The certificates of all members shall be subject to any and all debts owed to the Cooperative by such members, and the Cooperative shall have a lien upon the certificates of the members and upon all moneys due to the members for any debts owing by the members to the Cooperative.

Article IX. Miscellaneous

Section 1. Fiscal Year. The fiscal year of the Cooperative shall begin on the first day of January and close on the last day of December.

Section 2. Adoption and Form of Seal. The seal of the Cooperative shall contain the name of the Cooperative in the form as impressed in the margin hereof, and the seal in that form shall be, and is hereby adopted as, the official seal of the Cooperative.

Section 3. Amendments to By-laws. The By-laws of the Cooperative may be altered, rescinded, or added to by the vote of a majority of the members present at a special meeting convened for such purpose or at a regular meeting (except with regard to the alteration of, amendment of, rescission of, or addition to Article II, Membership, which shall require a vote of 2/3 of the Cooperative membership), but the notice of the special or regular meeting must set forth fully and clearly the proposed alteration, amendment, or rescission.

Dr. Crane testifies

(Continued from page 13)

cal Society urges the Committee to obtain testimony from the insurance companies writing malpractice insurance in Pennsylvania on the effect of limitless awards. We have been told that soaring verdicts are largely responsible for the skyrocketing premiums. One of the first things that Indiana did, in passing its landmark malpractice insurance reform law, was to put a cap on awards.

The resources of this state are finite, in medical care as well as energy. This Committee must find a balance—a balance between the cost of health care for all Pennsylvanians this year, next year, five years from now, and the right of an individual to extract an unlimited amount of money from the system.

What price shall we put on a limb or a life? Indeed what is an eye or an arm or a leg worth? Why is a leg lost in an accident worth $60,000 and one lost in an alleged malpractice case worth $600,000 or a million? For what amount of money would you be willing to give up an arm or leg? A horrible thought. On the other hand, what is society able to afford? What are we paying now? A million dollars? Hardly. The widow of a Vietnam veteran receives $300 a month for life. Even if she receives benefits for 60 years, she would receive less than the average jury award in the U.S. today. That's how much the federal government allows. That's how much we as a nation have said we can afford. What about workman's compensation? The maximum amount for death is less than $500 a month, which in the widow's normal lifetime would not reach the current average jury award.

What shall we do if we price health care out of the reach of our old people? How will state government be able to purchase medical care for the indigent?

Section 604 which permits punitive damages is counterproductive. Such punitive damages demonstrate again how the currently abused and misused malpractice system punishes those who can least afford it, the sick and injured. Punitive monetary damages add to insurance costs, which are ultimately paid by patients. A true punitive act, when one is justified, would be to turn evidence over to the State Board of Medical Education and Licensure for investigation and action to ensure that a bad physician does not hurt another patient. The State Board is the body of the state legally responsible for protecting consumers from bad doctors. Under the new Medical Practice Act, which the Pennsylvania Medical Society secured passage of last year, that Board has the authority to discipline bad doctors. What is urgently needed is the return of licensing fees to the State Board, as required in HB 805, so that it may hire the necessary investigators and attorneys, to go after alleged incompetent doctors.

It has been said that physicians are trying to avoid accountability for their mistakes. That physicians wish to take away patients' legal rights. The Pennsylvania Medical Society wants to weed out bad doctors. But only the state has the legal authority to do so. The State Medical Society has been urging proper funding of the State Board of Medical Education and Licensure to protect the public. The Pennsylvania Medical Society wants to make it easier for patients to exercise their legal rights and to have a mechanism that is responsive to their rights. We do say that some limit on the size of awards is needed to prevent the system from going bankrupt.

If the law, lawyers and legislators are interested in removing the incompetent doctor, this is done by revoking his license to practice, not by taking money from the pockets of sick people to pay unreasonable awards. Yet I do not know and you do not know of any case where a plaintiff's lawyer on winning a case has ever gone to the District Attorney or the Board of Medical Education and Licensure to have the defendant removed from practice!

Plaintiffs' lawyers will tell you that the threat of a malpractice suit keeps physicians on their toes. Quite the reverse; the threat demands that the doctors do things to satisfy a lawyer acting as a Monday morning quarterback - not the medical condition of the patient. In the seven medical schools of New York City there are seven professors of neurosurgery. They are among the most highly respected and competent specialists in the nation. Right now there are 25 suits against them for a total of $63 million. Seven bad doctors? No. Seven very good doctors to whom have been referred some of the most difficult cases possible. Seven high risk targets with the potential for high verdicts. Unfortunately, the current malpractice system is a kind of roulette game in which a few big winners take all, while the average patient pays and pays.

Section 605, dealing with attorneys' fees legalizes the worst aspects of the present system. It calls for a fee of one-third plus expenses - exactly the current practice; great for getting legislation passed and milking the public at the same time. And what is worse, expenses and fees are both in addition to any award, thus generating an increased cost to the system. Fine for some lawyers, but a tragedy for the public. The current customary fee is 33⅓%, plus expenditures, and this will be legislated as the only fee. Other states have seen fit to be more specific on the contingency fee. In fact, an earlier draft of this measure, as announced by the Governor, contained such a scale. The bill in its present form windowdresses the issue of the contingency fee.

Pennsylvania's statute of limitations must be addressed; it is an important key to the eventual solution of the malpractice crisis. Unfortunately, the present section 607 is a whitewash. It codifies the existing mess. By allowing the statute to run one year from discovery, it guarantees the possibility that we shall have a Gail Kalmowitz case in Pennsylvania. In that case, 18 years after the fact, she sued a physician for blindness allegedly caused by oxygen treatment during the first days of life, despite the fact that it wasn't until several years later that oxygen was confirmed as a contributing cause of blindness.

While the bill proposes to set a limit of three years, it really masks a six year limit through using pain and suffering. There is no case without pain or suffering; and six years is now the average time between the occurrence of an incident and settling of a claim.

Insurance companies are unanimous in their call for reform of the statute of limitations. Setting aside reserves for one year or two years in advance is difficult enough in these times of double digit inflation, but establishing reserves for a case which may be filed 20 years from now is beyond the realm of reason. What size will awards be by then and what premium should be charged now to set up reserves? No insurance company can prove that it needs a specific amount of reserves, and no Insurance Department can prove it doesn't need the reserves, for the whole matter of setting reserves requires the use of a very cloudy crystal ball.

True reform of the statute of limitations is vital, as called for in House Bill 805.

Mr. Chairman, according to our information, you will find that insurance companies are not willing to write malpractice insurance on a large scale in the private market until you meaningfully reform the statute of limitations.

We have grave reservations about the Joint Underwriting Association called for in section 801. While we support the intent "to make available patients compensation insurance at a reasonable cost," we see no evidence to indicate that the JUA as proposed can do so at "reasonable cost." Indeed, a better objective would be "at lower cost" and the burden of that lies squarely on the drafters of the bill.

The largest insurer of physicians in Pennsylvania, the Medical Protective Company of Fort Wayne, Indiana, should be asked to testify on the JUA.

So much for what's in House Bill 1367. It is a poor bill, a bad bill. It corrects none of the basic deficiencies of the present system but guarantees their perpetuation through enactment as law.

If you really want to address this problem and to correct the causes, you should drop 1367 and pursue 805, whose only deficiency is that it directly addresses the issues and proposes corrections of the root causes of the mess. Let me give you some examples.

Insurance industry people, attorneys and physicians in other states, tell us, "You're from Pennsylvania, you're the ones with that terrible Informed Consent rule." Pennsylvania's present law is so burdensome that one physician has said it would take him an hour to explain to a patient all the possible complications from taking aspirin. Not only must the physician tell the patient all of the possible complications and alternative treatments but he must somehow be sure that the patient, who is sick, anxious, perhaps disoriented, and in pain, understands the whole explanation. Right now, today, there are needed treatments and surgical procedures being withheld because physicians, sometimes under advice of their own legal counsels, believe they cannot get an informed consent that will hold up. The result is bad medicine; needless suffering. Truly defensive medicine at its worst. House Bill 805 calls for the return of informed consent to a reasonable basis.

Another newly developing legal ploy is popularly known as "promises to cure." Plaintiffs under advice of counsel say, "but you promised to cure me and you didn't." Medicine, an ancient and honored art, will continue to be an art so long as genetics continues to produce unique human beings. The only time that a promise to cure should be honored in a court of law is when it is in writing and signed by the patient and the physician, as stated in House Bill 805.

Expert witnesses should be just that, experts in the specialty or procedure under question. Recently, a physician lost a case in Pennsylvania when a non-radiologist gave expert testimony as to the customary practice of radiologists in similar situations in that community. Expert witnesses must be experts in the specialty or procedure in question, as required in HB 805.

In addition, we are seeing more and more of what has come to be known as "sloppy discovery." The result is that in some cases, where numbers of physicians or physician corporations are involved, everybody on the letterhead is named in the suit. Such frivolous claims are a waste of time and money. They are costly because they must be defended. Under present law, physicians pelted by frivolous or malicious claims have little practical recourse. House Bill 805 provides for counterclaim for damages for abuse of process which may be filed and litigated in the same action.

Ladies and gentlemen, Pennsylvania is ready to explode. I cannot emphasize to you too strongly that the physicians in this state want only one thing: to take care of their patients, but the malpractice system is making everybody sick. Basic legal principles such as informed consent and the statute of limitations have been exploited and abused. Settlements and awards are headed for outer space. Ultimately bearing the burden of these presently limitless settlements are the patients and with them the employers and employees in Pennsylvania. If this legislature is serious about wanting to contain the rising cost of medical care, then it must honestly reform one of the components of that care, the malpractice insurance system for hospitals and physicians. You must find a way to weigh the daily needs of all our people for medical care against the legal rights of the individual. And this must be done at a cost Pennsylvanians can afford to pay. House Bill 1367 defines the problem well but provides no answers. House Bill 805 does provide the answers. It's time that your committee and the Legislature move that bill. Some members of your committee have said that 805 is unconstitutional. We say work with us to make it constitutional without destroying its effectiveness in correcting the faults of the present system. To this end I and the members of the Society will be pleased to work with you.

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pennsylvania medicine

August 1975

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Special Session House of Delegates

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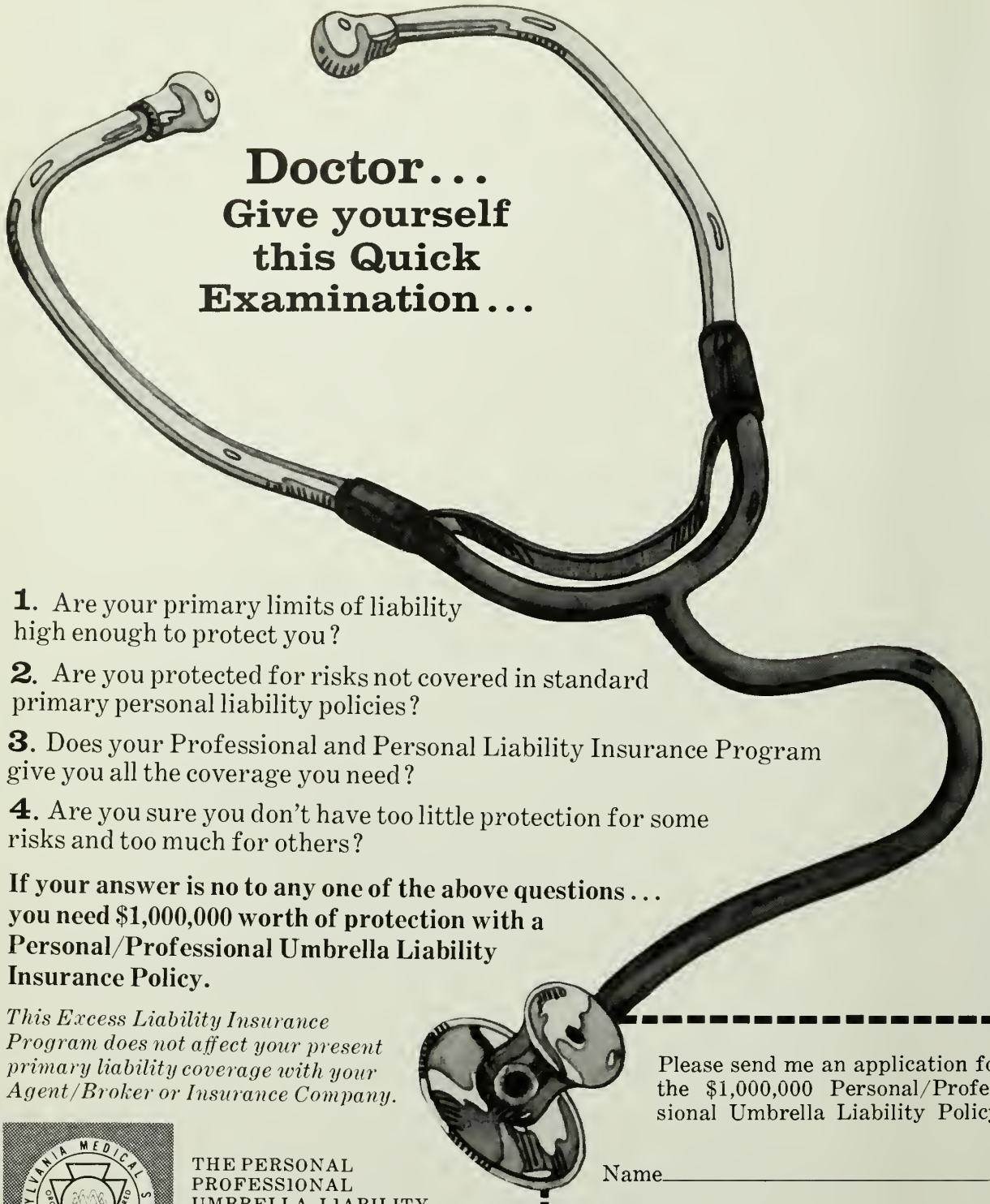

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BULLETIN: HOUSE OF DELEGATES STILL IN RECESS The Board of Trustees has reconsidered its action to call the special session of the House of Delegates out of recess August 13 and 14. The House will not meet on those days. The Senate Insurance Committee is working on amendments to H.B. 1367 (see below) and is expected to have a bill ready for a vote in September. "We are postponing the meeting," said Cyrus B. Slease, M.D., chairman of the Board of Trustees, "because we see encouraging signs in the activity by the leadership of the Legislature which we hope will produce a law that will ease the deepening health care crisis in Pennsylvania."

H.B. 1367 PASSED UNANIMOUSLY The Pennsylvania House of Representatives July 21 approved by a vote of 187-0 a malpractice bill, H.B. 1367, and sent it to the Senate, where it was referred to the Insurance Committee. The bill establishes 12 regional arbitration panels--one in each PSRO area--composed of two physicians, two lawyers, and one layman to hear medical malpractice cases and grant justified awards. It establishes a seven year statute of limitations, makes provision for a backup Joint Underwriting Association, and returns to the State Board of Medical Education and Licensure and the State Board of Osteopathic Examiners the registration fees paid by physicians to be used in enforcing the provisions of the practice acts governing the two professional groups. It creates a Medical Professional Liability Loss Fund to be operated by the state and funded through a maximum 10 percent surcharge on premiums of M.D.s, D.O.s, podiatrists, hospitals, and nursing homes. The fund would be used to compensate patients who receive awards in excess of $100,000. This means that insurance companies will pay only up to $100,000 per occurrence, with any amount over that coming from the fund which will be administered by the Insurance Department. At a special meeting of the Society's Board of Trustees held July 25, the Board reconfirmed its support of the principles in H.B. 805, some of which are incorporated in the legislation passed by the House of Representatives, and gave the Ad Hoc Committee authority to seek amendments when the Senate Insurance Committee studies the bill. Lowering the statute of limitations from seven years to two years and one year after the discovery of a foreign body is a Society goal. The bill now states that PSRO norms and standards be made available to arbitration panels. The Society seeks elimination of this provision because it results from a basic misunderstanding of the function of PSRO review and could adversely affect patient care. Presently the bill calls for the abolition of risk categories in professional liability insurance unless the General Assembly acts on recommendations of a study commission by July 1, 1977. The State Society seeks elimination of this provision which would have all physicians practicing in Pennsylvania pay the same premium without any study or gathering of evidence to prove the benefits of such a move.

PLAN C AGREEMENT APPROVED FOR GROUPS The State Insurance Department has approved Pennsylvania Blue Shield's new Plan C agreement for marketing to groups of over 100 as an experimental program. According to Blue Shield the primary differer between Plan C and Blue Shield Prevailing Fee 100, its best plan, is that payment for services under Plan C is made on a fixed schedule basis. Blue Shield will pay a fixed fee for a specific procedure or the doctor's charge, whichever is lower. Plan C contains a provision for periodic adjustments of the fee schedule allowances to meet prevailing economic conditions. Income limits are $6,000 for an individual and $12,000 for a family.

AMA COURT VICTORY UPHELD The Seventh Circuit U.S. Court of Appeals has affirmed a Federal District Court order enjoining former HEW Secretary Caspar Weinberger from enforcing utilization review regulations originally scheduled to become effectiv early this year. According to the court, the record in the case "reveals that a decision not to issue a preliminary injunction may have resulted in irreparable injury to patients and physicians."

MEDICAL PROTECTIVE SEEKS INCREASE Hearings were held July 28 by Insurance Commissioner William J. Sheppard on a 75 percent overall rate increase in premiums for professional liability insurance filed by Medical Protective Co. The rate request, if granted, would generate an additional $1.8 million in revenue and affect 6,600 physicians and 4,000 dentists in Pennsylvania The company received a 44 percent rate increase generating an extra $1.2 million in July 1974.

BLUE CROSS BENEFITS RESTORED Governor Milton J. Shapp has signed a law restoring coverage to patients of 30 Philadelphia area hospitals that have been involved in a dispute with Blue Cross for 18 months. The new law, Act 94 of 1975, extends the time period in which a hospital can sever relations with an insurance carrier. Terms are retroactive so that persons treated at the hospitals during the last 18 months will have full hospital bills paid under the old contract terms. Hospitals seeking to sever contrac must file a notice of intent 90 days in advance with the Insurance Department. The department then can postpone the cancellation of the contract while it conducts investigations and hearings.

ABORTION PAY REGULATION INVALID The U.S. Third Circuit Court of Appeals has ordered the Department of Public Welfare to pay for nontherapeutic or elective abortions for those on the state's medical assistance program. The opinion reads in part: "Since the decisions of the Supreme Court have forced the states to include elective abortion in the legal practice of medicine through the second trimester of pregnancy, we also hold the federal statute requires Pennsylvania to fund abortions through the end of the second trimester." The Department of Health said that a total of 16,247 abortions were reported in the Commonwealth during the last quarter of 1974 and the first quarter of 1975. This was the first report since the department was required to collect the data by the Abortion Control Act of 1974.

pennsylvania medicine

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PENNSYLVANIA MEDICINE, established in 1897, is published monthly as the official publication of the Pennsylvania Medical Society. All original papers and correspondence should be directed to the Managing Editor. Subscription requests and changes of address should be sent to PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043. A subscription is $5.00 per year. Single issues are 50 cents. Second class postage is paid at Lemoyne, Pennsylvania 17043.

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According to her major
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ıough primarily one of ex-
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ium is pronounced and
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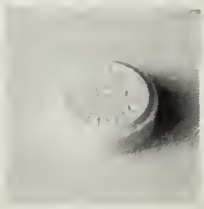

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tropics or anticonvulsants, consider
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ction. Usual precautions indicated in
ents severely depressed, or with latent
ression, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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president's page

House of Delegates acclaims president's address

Because of numerous requests for copies of the address of A. Reynolds Crane, M.D., Society president to the Special Session of the House of Delegates, July 2-3, 1975, PENNSYLVANIA MEDICINE reprints it in full here. Full proceedings of the session will appear in the September issue.

This Commonwealth is slipping into the worst health care crisis it has ever known. Quietly, one by one, physicians all across the state, as they open their mail and stare at the extortion notes in their hands, otherwise known as professional liability premium notices, are boarding up their offices and going out of practice. Older physicians who had hoped to gradually limit their practices, have no choice but to carry a full load, or stop abruptly. Part-timers must give up. High risk specialists find it no longer worthwhile to work 60 and 70 hours a week in order to subsidize an insurance company and the legal profession. There is already a problem of availability of medical care in this state. We have fought long and hard to increase the number of medical students in Pennsylvania, particularly students from Pennsylvania. We have fought for increased state aid for medical students and medical schools. We have supported legislation which would establish family medicine residencies in community hospitals. And now, as the fruits of these labors near maturity, they are about to be destroyed.

How can we promise physicians to a shortage area, when we cannot persuade doctors to stay in Pennsylvania, let alone immigrate to Pennsylvania under the present pernicious malpractice climate? This past month our medical schools graduated 961 young doctors, second to none in the world, but we shall not be able to keep them. Other states such as Indiana, where meaningful malpractice reform has been taken, beckon them.

Allegations that malpractice suits are the result of the practices of bad doctors are belied by the fact that at our teaching hospitals, where the art and science of medicine

(Continued on page 70.)

Special house session in recess — not adjourned

The special session of the Society's House of Delegates, called to consider possible action in the face of the professional liability insurance crisis, stands in recess after having rejected seven resolutions calling for a statewide restriction of medical services. The move to recess permits reconvening of the delegates on short notice if the Legislature fails to enact corrective legislation to alleviate the crisis.

The 205 delegates who attended the session at the Penn Harris Motor Inn, Camp Hill, considered 30 resolutions and several recommendations from A. Reynolds Crane, M.D., Society president, whose address is reprinted in full beginning on page 6 of this issue.

Although they rejected resolutions calling for restriction of services because "... physicians find the concept of restricting services contrary to the traditional principles of medical ethics," delegates adopted a substitute resolution which states that the "special session be reconvened to give serious consideration to the matter of a statewide slowdown at the appropriate time." Also authorized is a mass demonstration in Harrisburg, if the Board of Trustees sees fit.

The use of binding arbitration by individual physicians was approved by delegates. The action was one of several alternatives to a slowdown offered by Dr. Crane in his address. To implement this, individual physicians would use a written agreement, signed by the patient prior to treatment, which states that if the patient is dissatisfied with the results of treatment, he must submit his case to arbitration for settlement. The agreement, which is to be put in final form by the Society's legal counsel and implemented as soon as possible by the Board of Trustees, would cover claims of negligence, malpractice, tort, or breach of contract, and is final unless the patient gives written notice to the contrary within 30 days of signing the form.

A resolution to assist physicians in counterclaims for "abuse of process" was adopted at the session because physicians have been "forced to accept suit-at-law stipulating so-called malpractice in a supine, toothless and defenseless fashion. . . ." Dr. Crane recommended, and the House approved, that the Medical Defense Fund be used to cover legal costs in such cases. The Board of Trustees was authorized to make a mandatory assessment of each Society member for general use in solving the malpractice insurance problem, including assisting members who file suits for abuse of process.

A summary of action on resolutions appears on page 8. Session photographs are on page 10.

In addition, Dr. Crane recommended that the Society declare it unethical for a physician to accept a fee for medical testimony and devise a system through which testimony will be furnished as a "friend of the court" rather than on an adversary basis. The House approved the recommendation and referred it to the Judicial Council for an opinion.

Dr. Crane's recommendation which suggested planning a Society "insurance program to be activated when meaningful legislation has been enacted," was adopted in conjunction with a resolution that a special committee be assigned to "detailed formulation" of the program.

The delegates resolved to step up the public relations campaign to enlist support from labor and the general public while pushing for amendment of H. B. 1367 to incorporate the principles spelled out in H. B. 805, the bill endorsed by the Society. H. B. 1367 was reported out of committee during the special session. Delegates reaffirmed their support of the principles in H. B. 805, as called for in five resolutions introduced at the session.

Sharply debated during the four-hour reference committee hearing on the first day of the session was the forcing of a rollback of professional liability insurance premiums— the subject of five resolutions. The House of Delegates in final action called on the Board of Trustees to look into the "feasibility of action for full disclosure of information needed to review rate increases, examine the justification for the rate structure now in effect, and report back to the House of Delegates at its next meeting. Along these lines was a resolution calling for release of the "Durkin Report," an actuarial report on the Argonaut rate increase ordered by the State Society. Delegates rejected the resolution that the report be made public, but recommended that it be made available at Society headquarters for interested members.

Unless the special session is called out of recess, the House of Delegates will next meet October 6-8, 1975, at the Host Farm Motel, Lancaster.

Summary of action on resolutions before delegates

75-S-7 75-S-12 75-S-16 75-S-25 75-S-26	Support the principles incorporated in H. B. 805.	Adopted along with recommendation for a day of mass demonstration.
75-S-3	Changes composition of Medical Review Panel in H. B. 805.	Adopted.
75-S-19	Sets up two-trial system to handle malpractice cases: preliminary trial to determine if malpractice or maloccurance, second trial to set or determine damages to patient.	Referred to Ad Hoc Committee on Malpractice.
75-S-2 75-S-5 75-S-8 75-S-15 75-S-17	Call for actions to roll back insurance premiums.	Referred to Board of Trustees.
75-S-18	Calls for the release of the Durkin Report.	Rejected, but with the recommendation that it be available at Society headquarters for personal perusal of any member.
75-S-28	Orders a poll of physicians insured by Argonaut to ascertain their true feelings regarding attempts to roll back premiums.	Adopted.
75-S-30	Urges release by the insurance commissioner to the public relevant information to justify insurance premium increases.	Adopted.
75-S-1 75-S-9 75-S-23 75-S-27	Call for slowdowns and other restrictions of services.	Substitute adopted: calls for letter to governor and state legislators opposing legislation now under consideration and urging adoption of principles in H. B. 805.
75-S-21	Urges support of slowdown if other alternatives are not apparent.	Amended. Amendment resolves that the House go into recess rather than adjournment and if adequate corrective legislation is not forthcoming that Board of Trustees reconvene the House to give special consideration to matter of statewide slowdown.
75-S-14	The Society should explore all legal means to resolve the problem.	Adopted.
75-S-11	Sanctions other than withholding services should be considered.	Adopted.
75-S-10	Calls for development of an emergency care plan for implementation in the event of forced curtailment of medical services.	Adopted.
75-S-4 75-S-29	Call for restriction of specific services.	Rejected with recommendation that some items included in 75-S-29 be studied further by PMS Board.
75-S-22	The State Society should support physician counterclaims in meritorious cases.	Adopted.
75-S-6	Calls for representation on the Board for certain specialty groups.	Withdrawn.
75-S-13	Calls for continued publicity and enlistment of the support of organized labor and authorizes a special assessment if necessary.	Adopted.
75-S-20	Calls for passing on of premium increases to patients in the form of surcharge on their bills.	Rejected with recommendation that individual physicians use their best judgment regarding this practice.
75-S-24	Calls for establishment of a Society formed and administered insurance company.	Adopted recommendation to develop plan on paper.

NOTE: resolutions were grouped by subject when the reference committee met to prepare its report.

Board recommends Blue Shield assistants' meetings

The Society Board of Trustees has recommended that members send their office assistants to meetings, sponsored by Pennsylvania Blue Shield, which explain their procedures and ways to expedite claims submissions. Meetings scheduled during the fall months are:

September 3, 10:00 a.m., Cherry Hill Hospital, Cherry Hill, NJ
September 3, 9:30 a.m., Holiday Inn, Butler
September 10, 10:00 a.m., Treadway Fiesta Inn, Willow Grove
September 10, 9:30 a.m., Jameson Hospital, New Castle
September 10, 9:00 a.m., Latrobe Hospital, Latrobe
September 16, 9:30 a.m., South Hills Village, Pittsburgh
September 17, 10:00 a.m., Lancaster General Hospital, Lancaster
September 17, 9:30 a.m., YWCA, Pittsburgh
September 17, 9:30 a.m., Beaver Falls Hospital, Beaver Falls
September 17, 9:30 a.m., West Allegheny Hospital, Oakdale
September 18, 9:00 a.m., Sheraton Motor Inn, Altoona
September 18, 9:30 a.m., McKeesport Hospital, McKeesport
September 19, 9:30 a.m., Brookville Hospital, Brookville
September 24, 10:00 a.m., Holiday Inn, Media
September 25, 9:00 a.m., Holiday Inn, Bedford
October 1, 10:00 a.m., Chestnut Hill Hospital, Philadelphia
October 1, 9:30 a.m., Mellon Pavillion, Pittsburgh
October 3, 10:00 a.m., Allegheny Valley Hospital, Natrona Heights
October 8, 9:30 a.m., Howard Johnson's Restaurant, Pittsburgh
October 8, 10:00 a.m., Holiday Inn, 13th and Walnut, Philadelphia
October 9, 9:00 a.m., Sheraton Motor Inn, Johnstown
October 15, 9:30 a.m., Holiday Inn, Meadville
October 15, 10:00 a.m., Trainers Restaurant, Quakertown
October 22, 10:00 a.m., Holiday Inn, City Line Ave., Philadelphia
October 28, 9:30 a.m., Ohio Valley Hospital, McKees Rocks
October 29, 9:30 a.m., Warren Hospital, Warren
October 29, 9:30 a.m., Homestead Hospital, Homestead
October 29, 10:00 a.m., Sheraton Motor Inn, Roosevelt Blvd., Philadelphia
October 30, 9:30 a.m., Southside Hospital, Pittsburgh
November 5, 9:30 a.m., Braddock Hospital, Braddock
November 5, 10:00 a.m., First Federal Savings and Loan Bldg., Pottstown
November 12, 10:00 a.m., Holiday Inn, 18th and Market, Philadelphia
November 12, 9:30 a.m., Suburban Hospital, Pittsburgh
November 13, 9:30 a.m., DeSoto's Holiday House, Bradford

Family physicians install new officers

The Pennsylvania Academy of Family Physicians held its 27th annual convention recently. John J. Hanlon, M.D., was installed as the academy's 29th president during the convention.

Other officers installed are: Leroy A. Rodgers, M.D., Johnstown, president elect; Edward J. Notari, M.D., Dunmore, vice president; Eddie Lee Clark, Jr., M.D., Philadelphia, secretary; and Walter C. Hill, M.D., York, treasurer.

Dr. Hanlon has served the academy as secretary, treasurer, vice president, and a member of the board of directors. He is a member of the American Academy of Sports Medicine, team physician for Mechanicsburg area schools, and advisor to the Mechanicsburg Board of Health.

THE MONTGOMERY County Medical Society marked a first when it arranged a joint meeting of the Boards of Trustees of three local hospitals to discuss the malpractice crisis. Shown above are, left to right, Alan L. Dorian, M.D., president elect of the county society; A. Reynolds Crane, M.D., State Society president, who addressed the meeting; and board chairmen M. Eugene Seltzer, Sacred Heart Hospital; Donald P. Horsey, Montgomery Hospital; and William Walkup, Suburban General Hospital.

Special house session reflects delegates' concern

THE GRAVITY of the issue before the special session of the Society's house of Delegates July 2 and 3 is reflected on the faces of physicians as they listened to the debate and spoke to fellow delegates.

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0.1 or 0.2 mg and chlorthalidone, 15 mg

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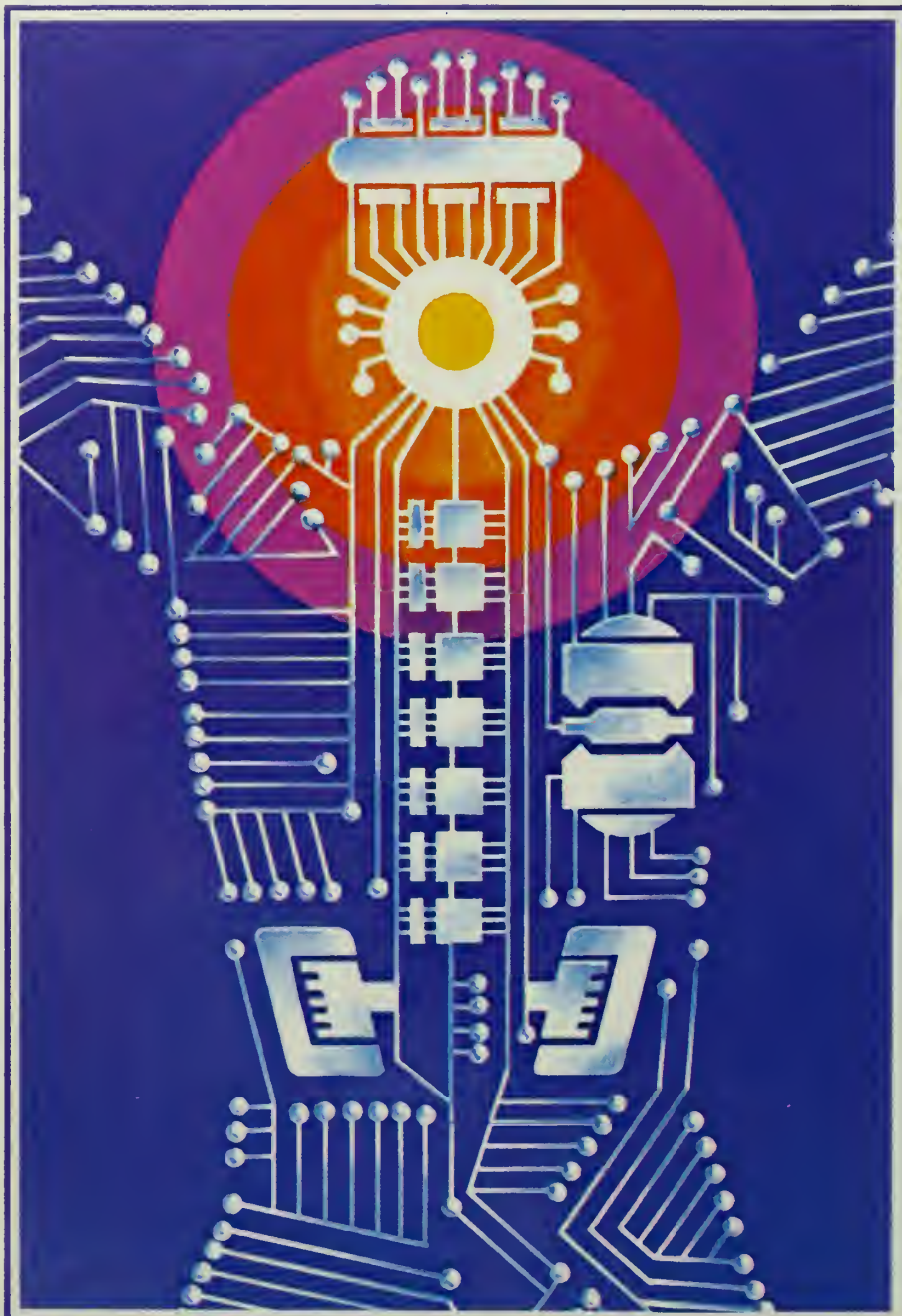


Catapres®
(clonidine hydrochloride)
contributes:

Action at the vasomotor centers as shown in animal studies—not a rauwolfia derivative or a sympathetic blocker or a "false transmitter"

Maximal blood pressure lowering without the weeks of delay common with the rauwolfia class of antihypertensives

Significant blood pressure reduction without alteration of normal hemodynamic responses to exercise

Mild and infrequent orthostatic hypotension

Little or no change in renal blood flow and glomerular filtration rate

Reduced plasma renin activity and excretion of aldosterone and catecholamines (see Actions section)

Combines Catapres (clonidine hydrochloride) with a diuretic—the only major new combination antihypertensive in a decade

Chlorthalidone contributes:

harmacologic action similar
) the thiazides

mooth, extended diuretic/
ntihypertensive effect

dditive or potentiating effect
n adjunctive antihypertensive
gents

ne most common adverse reactions with
ombipres are dry mouth, drowsiness, and
dation. As with thiazide-containing combi-
ation antihypertensives, hypokalemia, hyper-
icemia, and decreased glucose tolerance
ay occur. Combipres is contraindicated in
atients with known sensitivity to chlorthali-
one and in those with severe renal or hepatic
sease.

lease see last page of advertisement for a
rief summary of the prescribing information
cluding precautions, warnings, and adverse
actions.

ee box Warning on next page concerning
ne appropriate use of Combipres.

new nonreserpine Combipres®

Each tablet contains:
Catapres®, brand of clonidine hydrochloride,
0.1 or 0.2 mg and chlorthalidone, 15 mg

.1 and .2

Works harder

Usually exerts a more pronounced antihypertensive effect than either component alone in equivalent doses*

Works broadly

Wide therapeutic range—mild to severe hypertension

Works conveniently

Simplifies therapy for the hypertensive patient who needs more than one drug*

Works for less

Costs less than two separate prescriptions*

Works and works and works

Convenience and economy encourage patients to stay on medication, help assure continued blood pressure control over the long course of therapy*

*__WARNING__ Combipres is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

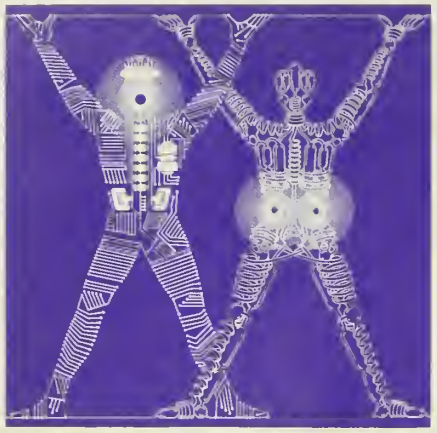
"he only major new combination antihypertensive in a decade

Works in the majority of hypertensive patients

Chlorthalidone vs Combipres
A Comparison of Standing Blood Pressure Response in 8 Studies

ean Optimum Daily Dose Chlorthalidone (mg)	50	50	47.7	50	50	50	71	50
Combipres (mg)	0.3	0.48	0.47	0.4	0.43	0.68	0.52	0.4
). of Patients ıo completed study	42	20	11	17	34	9	31	9
udy	1	2	3	4	5	6	7	8

ease see last page of advertisement for a brief summary of the prescribing information including precautions, warnings, and adverse reactions.



nonreserpine

new Combipres

Each tablet contains: Catapres®, brand of clonidine hydrochloride, 0.1 or 0.2 mg and chlorthalidone, 15 mg

Guidelines for Titrating Catapres and Chlorthalidone Dosages:
Initial doses: Catapres—one 0.1 mg tablet twice daily. Chlorthalidone—50 mg daily.

Dosage increments: While daily chlorthalidone doses remain at 50 mg, further increments of Catapres of 0.1 mg or 0.2 mg per day can be made at intervals of 2 to 14 days depending on severity of hypertension. The usual daily dose of Catapres ranges between 0.2 and 0.8 mg. Studies indicate that 2.4 mg is the maximum effective daily dose, but doses as high as this have rarely been used.

Combipres®

Each tablet contains:
Catapres®, brand of clonidine hydrochloride, 0.1 or 0.2 mg and chlorthalidone, 15 mg

WARNING: This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

Actions: Catapres (clonidine hydrochloride): The mechanism of action appears to be central alpha-adrenergic stimulation as demonstrated in animal studies. This results in inhibition of bulbar sympathetic cardioaccelerator and sympathetic outflow from the brain. Other studies in humans have provided evidence of a reduction in plasma renin activity and the excretion of aldosterone and catecholamines. The exact relationship between these pharmacologic actions of Catapres (clonidine hydrochloride) in humans and its antihypertensive effect has not been fully elucidated at this time.

Chlorthalidone: The diuretic action of chlorthalidone is thought to be due to inhibition of sodium and chloride reabsorption in the proximal tubule.

Indication: The drug is indicated in the treatment of hypertension (see box warning).

Contraindications: Patients with known hypersensitivity to chlorthalidone and patients with severe renal or hepatic diseases.

Warnings: Tolerance may develop in some instances necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxicity findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefit outweighs the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Combipres in children.

Precautions: When discontinuing Combipres, reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of Combipres therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect of the clonidine hydrochloride component. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other antihypertensive agent, Combipres should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Combipres should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmological findings have been recorded with Catapres, in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Patients predisposed toward or affected by diabetes should be tested periodically while receiving Combipres, because of the hyperglycemic effect of chlorthalidone.

Because of the possibility of progression of renal failure, periodic determination of the BUN is indicated. If, in the physician's opinion, a rising BUN is significant, the drug should be stopped.

The chlorthalidone component of Combipres may lead to sodium and/or potassium depletion. Muscular weakness, muscle cramps, anorexia, nausea, vomiting, constipation, lethargy or mental confusion may occur. Severe dietary salt restriction is not recommended in patients receiving Combipres.

Periodic determinations of the serum potassium level will aid the physician in the detection of hypokalemia. Extra care should be given to detection of hypokalemia in patients receiving adrenal corticosteroids, ACTH or digitalis. Hypochloremic alkalosis often precedes other evidence of severe potassium deficiency. Frequently, therefore, more sensitive indicators than the potassium serum level are the serum bicarbonate and chloride concentrations. Also indicative of potassium depletion can be electrocardiographic alterations such as changes in conduction time, reduction in amplitude of the T wave; ST segment depression; prominent U wave. These abnormalities may appear with potassium depletion before the serum level of potassium decreases. To lessen the possibility of potassium deficiency, the diet, in addition to meat and vegetables, should include potassium-rich foods such as citrus fruits and bananas. If significant potassium depletion should occur during therapy, oral potassium supplements in the form of potassium chloride (3 to 4.5 gm/day), fruit juice and bananas should be given.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy.

Clonidine hydrochloride: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one case of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash; impotence, urinary retention; increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Chlorthalidone: Symptoms such as nausea, gastric irritation, anorexia, constipation and cramping, weakness, dizziness, transient myopia and restlessness are occasionally observed. Headache and impotence or dysuria may occur rarely. Orthostatic hypotension has been reported and may be potentiated when chlorthalidone is combined with alcohol, barbiturat or narcotics. Skin rashes, urticaria and purpura ha been reported in a few instances.

A decreased glucose tolerance evidenced by hyperglycemia and glycosuria may develop inconsistentl This condition, usually reversible on discontinuatio of therapy, responds to control with antidiabetic treatment. Diabetics and those predisposed should be checked regularly.

As with other diuretic agents hypokalemia may occ (see Precautions). Hyperuricemia may be observed on occasion and acute attacks of gout have been p cipitated. In cases where prolonged and significan elevation of blood uric acid concentration is consi ered potentially deleterious, concomitant use of a uricosuric agent is effective in reversing hyperurice mia without loss of diuretic and/or antihypertensiv activity.

Idiosyncratic drug reactions such as aplastic anem thrombocytopenia, leukopenia, agranulocytosis, an necrotizing angiitis have occurred, but are rare.

The remote possibility of pancreatitis should be co sidered when epigastric pain or unexplained gastro intestinal symptoms develop after prolonged administration.

Other adverse reactions which have been reported with this general class of compounds include: jaun dice, xanthopsia, paresthesia and photosensitizati

Overdosage: Catapres (clonidine hydrochloride): Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followe the accidental ingestion of Catapres by several chi dren from 19 months to 5 years of age. Gastric lava and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazolin in intravenous doses of 10 mg at 30-minute interval abolishes all effects of Catapres overdosage.

Chlorthalidone: Symptoms of overdosage include nausea, weakness, dizziness, and disturbances of electrolyte balance. There is no specific antidote, b gastric lavage is recommended, followed by suppor tive treatment. Where necessary, this may include intravenous dextrose and saline with potassium administered with caution.

How Supplied: Combipres® 0.1 (Each tablet contai clonidine hydrochloride, 0.1 mg + chlorthalidone, 15 mg). It is available as pink, oval, single-scored compressed tablets in bottles of 100.

Combipres® 0.2 (Each tablet contains clonidine hydrochloride, 0.2 mg + chlorthalidone, 15 mg). It available as blue, oval, single-scored compressed tablets in bottles of 100.

For complete details, please see full prescribing information.

References: 1. Becker, M. C : Data on file at Boehringer Ingelheim Ltd. **2.** Belle, M. S.: Data on fil at Boehringer Ingelheim Ltd. **3.** Hall, B. H.: Data on file at Boehringer Ingelheim Ltd. **4.** McDonald, R. L Data on file at Boehringer Ingelheim Ltd. **5.** Parsons W. B., Jr.: Data on file at Boehringer Ingelheim Ltd **6.** Russell, R. P.: Data on file at Boehringer Ingelheim Ltd. **7.** Winemiller, R. H.: Data on file at Boehringer Ingelheim Ltd. **8.** Yeh, B : Data on file at Boehringer Ingelheim Ltd.

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Does the Boggle have a case on you?

The LEKTRIEVER® 600 mechanized file can turn it into a case history!

If you have an active, moderate-sized office using a conventional filing system, chances are the Boggle finds you irresistible.

Decentralized or overcrowded files give the Boggle plenty of opportunities to carry on his love affair with your vital, active records. A Boggled filing system wastes time and space... and can cause costly, embarrassing mistakes.

The LEKTRIEVER 600 is a modern **electric lateral file,** specially designed for busy offices with moderate file volume. In fact... it may be the only file you need! It holds as much as six conventional four-drawer cabinets (600" of filing space) in a single, compact, attractive unit.

The LEKTRIEVER 600 centralizes your records within easy reach. Records are delivered within seconds at the push of a button. No more bending, stretching or searching! It arrives fully assembled, plugs into any 110-120 volt outlet, and is simple and safe to operate.

The LEKTRIEVER 600 mechanized file has brought many of the Boggle's love affairs to an abrupt end... and we have the case histories to prove it! Use the coupon below to tell us about the "bugs" in your filing system, and we'll show you how the LEKTRIEVER 600 has helped solve a similar problem. And who knows... we may be writing our next case history about **you!**

SPERRY REMINGTON
P.O. Box 1000 (Dept. 100) -I
Blue Bell, PA 19422

Please send a case history describing how the LEKTRIEVER 600 mechanized file solved a filing system problem similar to ours. I understand I am under no obligation.

Type of office _____

Our biggest filing problem _____

_____

Name _____

Company _____

Address _____

City _____

State _____ Zip _____

SPERRY REMINGTON
OFFICE SYSTEMS AND MACHINES

SPERRY REMINGTON IS A DIVISION OF SPERRY RAND CORPORATION

SEXUAL DYSFUNCTION: WHEN TO COUNSEL — WHEN TO REFER

•Two day conference: September 19 and 20

Sponsored by:

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
AMERICAN ASSOCIATION OF MARRIAGE AND FAMILY COUNSELORS - WESTERN PENNSYLVANIA DIVISION

Topics to be covered include:
Historical Overview
Sexual Development: Problems of Gender Identity
Sexual Orientation
Reserach Problems in study of Human Sexuality
Current Treatment Methods
Differences between couples seeking marriage counseling and sex therapy

The conference will be held at Western Psychiatric Institute and Clinic

to register send $35 check payable to Sexual Dysfunction Conference to: Mrs. Leda Hanin, Room 996, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15261

Registrants are responsible for making their own hotel reservations, the Institute is 5 minutes from the Webster Hall Hotel in Oakland and 15 minutes from downtown accommodations.

This Continuing Medical Education offering meets the criteria for six hours of credit in Category I for the Physician's Recognition Award of the American Medical Association.

This program is presented in cooperation with the Division of Continuing Education, University of Pittsburgh School of Medicine.

Registration blank

NAME _____ ADDRESS _____

PROFESSION _____ AMT. ENCLOSED _____

Enrollment is limited to 150 participants
Registration closes September 5, 1975

Pro-Banthine®
brand of
propantheline bromide

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to: G. D. Searle & Co. Medical Department, Box 5110, Chicago, Ill. 60680 481

"Antiacid" action for ulcer patients...

one of the many things you need in an anticholinergic.

Pro-Banthine is considered adjunctive in total peptic ulcer therapy that may include diet, conventional antacids, bed rest, and other supportive measures.

Pro-Banthine is provided in several different dosage forms which will meet virtually any clinical need. It is just as versatile in filling patient needs, among which are:

"Antiacid" action—Pro-Banthine® (propantheline bromide) reduces gastric secretory volume and resting total and free acid.

"Analgesic" action—Pro-Banthine helps to control the acid-spasm-pain complex.

Vigorous anticholinergic action—Pro-Banthine® Vials, 30 mg., are for intramuscular or intravenous use when prompt and vigorous anticholinergic action is required.

Mild anticholinergic action—Pro-Banthine® Half Strength, 7.5 mg. tablets, for more exact adjustment of maintenance dosage in mild to moderate gastrointestinal disorders.

Pro-Banthine®
(propantheline bromide)

a good option in peptic ulcer

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

makes sense

For long-term control of hypertension*

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* WARNING

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

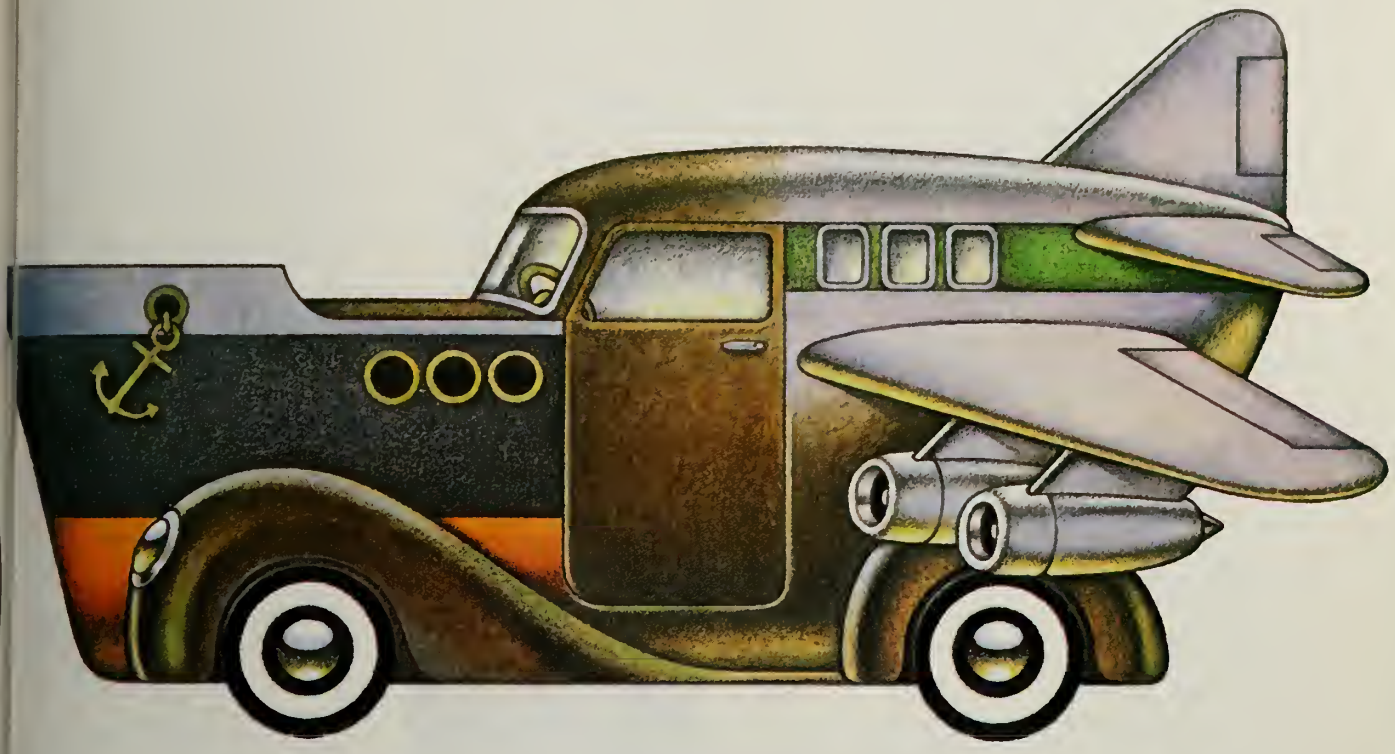
Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630

Subsidiary of SmithKline Corporation

'DYAZIDE'

Just once or twice daily for maintenance. Hydrochlorothiazide to help keep blood pressure down and triamterene to help keep potassium levels up.



On land, sea, and in the air...

Up to 24 hours of effective control with a single dose...in nausea, vomiting and dizziness associated with motion sickness.

Dosage: 25 to 50 mg. 1 hour before travel.

Available on prescription only.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

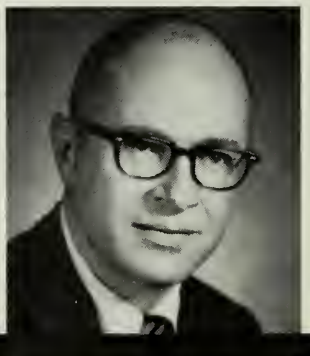
ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25 Chewable Tablets
(meclizine HCl) 25 mg.

for motion sickness

Opinion & Dialogue

Should a specially prepared package insert be made available to patients?



Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration

The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progestone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
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Tape Presentations Medical Arts '74

An Overview of Acupuncture

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☐ **A105:** Acupuncture: A Therapeutic Modality—Nathan Sussman, M. D., Harrisburg, Pennsylvania. 25 min.

☐ **A106:** Acupuncture and Its Role in Anesthesia—James C. Erickson, III, M. D., Professor of Anesthesiology, Jefferson Medical College. 30 min.

☐ **A107:** Acupuncture in the Management of Intractable Pain—Mary E. Moore, Ph. D., M. D., Assistant Professor of Medicine, Temple University Health Sciences Center. 20 min.

☐ **A108:** Mechanism and Management of Chronic Pain—Jewell L. Osterholm, M. D., Professor of Surgery (Neurosurgery) and Director, Division of Neurosurgery, Hahnemann Medical College and Hospital. 35 min.

The Physician, The Patient and Long-Term Care

☐ **A110:** Our Role in the Care of the Aging—Nathan Sussman, M. D., Medical Director, Dauphin County Home and Hospital, discusses the role of medical and allied professions in the care of the aging. 11 min.

☐ **A111:** Applied Geriatrics—Joseph T. Freeman, M. D., Philadelphia, Pennsylvania, discusses new circumstances in older age which reassign obligations but do not lessen responsibilities, the need to make judgments in terms of the older person who is living and dying in accordance with new social imperatives, and overtones to life in old age that cannot be judged by rules of survival at all costs. 25 min.

☐ **A112:** Commonly Encountered Medical Problems of the Elderly—Thomas Hart, M. D., Consultant and Member of Faculty, Harrisburg Hospital Family Practice Residency Program. 18 min.

☐ **A113:** Demonstrating Quality Control—Leslie Fox, Joint Commission on Accreditation of Hospitals, discusses the development of a quality control program in long-term care facilities. 98 min. (Provide Two Cassettes)

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PROLOID® (thyroglobulin)

Caution: Federal law prohibits dispensing without prescription.

Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T_4 and T_3 in Proloid (thyroglobulin) is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, $T_3{}^{131}I$ resin sponge uptake, $T_3{}^{131}I$ red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Instructions for Use. The following conversion table lists the approximate equivalents of other thyroid preparations to Proloid (thyroglobulin) when changing medication from desiccated thyroid, T_4 (sodium levothyroxine), T_3 (sodium liothyronine), or T_4/T_3 (liotrix).

CONVERSION TABLE

Dose of Proloid (thyroglobulin)	Dose of Desiccated Thyroid	Dose of T_4 (sodium levothyroxine)	Dose of T_3 (sodium liothyronine)	Dose of liotrix (T_4/T_3)
1 grain	1 grain	0.1 mg	25 mcg	#1 (60 mcg/15 mcg)
2 grains	2 grains	0.2 mg	50 mcg	#2 (120 mcg/30 mcg)
3 grains	3 grains	0.3 mg	75 mcg	#3 (180 mcg/45 mcg)
4 grains	4 grains	0.4 mg	100 mcg	
5 grains	5 grains	0.5 mg	125 mcg	

In changing from Thyroid USP to Proloid (thyroglobulin), substitute the equivalent dose of Proloid (thyroglobulin). Each patient may still require fine adjustment of dosage because the equivalents are only estimates.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

Supplied. ¼ grain tablets in bottles of 100 (N 0047-0250-51) and 1000 (N 0047-0250-60); ½ grain tablets in bottles of 100 (N 0047-0251-51) and 1000 (N 0047-0251-60); scored 1 grain tablets in bottles of 100 (N 0047-0252-51) and 1000 (N 0047-0252-60); 1½ grain tablets in bottles of 100 (N 0047-0253-51) and 1000 (N 0047-0253-60); scored 2 grain tablets in bottles of 100 (N 0047-0257-51); 3 grain tablets in bottles of 100 (N 0047-0254-51) and 1000 (N 0047-0254-60); scored 5 grain tablets in bottles of 100 (N 0047-0255-51) and 1000 (N 0047-0255-60). Full information is available on request. P-GP-51 4/c

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Please see adjoining column for brief summary of prescribing information.

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Caddy (No Carts) - Gratuities - Door Prizes

also

McKee Cup - Blue Shield Handicap -
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*Buffet - 11:30 a.m. - 12:45 p.m.
"Shotgun Start" at 1:00 p.m.
Dinner at 7:00 p.m.

ENTRY FORM

Limited to 120 Golfers
Entry Deadline September 8

$60 Entry Fee Includes
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Name _____

Address _____ Zip _____

- "Shotgun Start" at 1:00 p.m.
- Caddy Only (No Carts)
- Please show proof of certified handicap on day of Tournament

Other members of foursome
(Not necessary to submit
foursome — single entries
are acceptable)

1. _____
2. _____
3. _____

Make check ($60.00) payable to: Pennsylvania Medical Golfing Assn.
20 Erford Road
Lemoyne, Pa. 17043

No fee refund after September 8

Getting prompt payment depends on input

Almost any day Medicare claims totaling some three quarters of a million dollars are sidetracked at Pennsylvania Blue Shield. Money due both doctor and patient is being held up needlessly.

These payments cannot be made because claim information is missing. Although doctors' offices are contacted for the necessary information, frequently days, weeks and even months go by before it is furnished. Meanwhile, payment to doctor or patient is delayed and claims lie unprocessed.

Want to speed up cash flow? Check your Medicare claim or bill you provide your Medicare patient to make sure it includes:

1. The **diagnosis** (if sensitive, ICDA code may be used).
2. The **type** of visit (brief, intermediate etc.) when this service is provided.
3. The **place** where laboratory tests were performed.
4. Your Pennsylvania Blue Shield doctor identification **number**.

These items of information are the most frequently missed on Medicare claims and bills submitted to Pennsylvania Blue Shield; you can help your cash flow by making sure your Medicare billing checklist includes them.

I.R. Perkin, Director
Medicare Operations
Pennsylvania Blue Shield

A Medicare Tip

CASH FLOW...TOO SLOW?

Today more than ever physicians are being called on for leadership . . . both in the profession and in the community. But if you want to lead you've got to communicate. And we can help.

How? By teaching you the latest techniques in oral communications—methods to help you through the toughest situations—from facing a TV camera to facing the PTA . . . by teaching you how to prepare yourself . . . how to analyze an audience . . . how to handle questions—even the tough questions that make you sweat now.

How? By assembling the best faculty possible—people who do the same type of programs for national advertising agencies . . . people who train corporation executives and national leaders.

How? By drilling . . . by using videotape and live practice sessions . . . you may sweat a little, but you'll learn a lot.

Communications and Leadership training seminar sponsored by the Communications Division of the Pennsylvania Medical Society—open to all PMS members.

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Host Farm Motel, Lancaster
October 5, 10 a.m. to 6 p.m. and 6, 8 a.m. to 11 a.m.

Enclosed is my check for $70 (covers tuition only). Participants are responsible for making their own reservations. If you'd like hotel reservation form check here ( ).

Name _____
Adress _____

Send to:
Pennsylvania Medical Society
Communications Division
20 Erford Road
Lemoyne, Pa. 17043

MDs in the news

Albert B. Resnick, M.D., Wyncote, was recently appointed as clinical director of the Human Development Center, the Greater Northeast Division of the Philadelphia Psychiatric Center. The Human Development Center, which was formally opened in January, provides counseling and guidance including crisis intervention and outpatient services with individual, family, and group therapy. The center receives referrals from other agencies in the community, physicians, and religious advisors in addition to individual persons needing help. The new facility is located in the Smylie Times Building on Roosevelt Boulevard.

DR. RESNICK

DR. WEIDNER

The Pennsylvania State University College of Medicine at the Milton S. Hershey Medical Center recently appointed **William A. Weidner, M.D.,** as associate dean for health care. Dr. Weidner will continue to serve as professor and chairman of radiology, a position which he has held since 1971 and as a medical advisor in radiology to Pennsylvania Blue Shield.

Harry Prystowski, M.D., recently received an honorary doctor of humane letters degree at the 146th commencement of the Medical University of South Carolina. Dr. Prystowski also received a silver sesquicentennial medallion at the program which marked the end of the year long celebration of the 150th birthday of the College of Medicine, the oldest medical school in the south. Dr. Prystowski is provost and dean of The Milton S. Hershey Medical Center.

William S. Frankl, M.D., professor of medicine and head of the division of cardiology, was recently awarded the Christian R. and Mary F. Lindback Award for Distinguished Teaching (clinical) at the 123rd commencement of the Medical College of Pennsylvania.

Alton I. Sutnick, M.D., will become dean of the Medical College of Pennsylvania September 1. He is currently associate director of the Institute for Cancer Research and director of clinical development of the American Oncologic Hospital, both in the Fox Chase Cancer Center, Philadelphia. Dr. Sutnick is on the faculty of the University of Pennsylvania and has been a visiting professor at the Medical College.

Paul Nemir, Jr., M.D., chief of surgery at the Graduate Hospital of the University of Pennsylvania, will address the International Society of Surgery and the International Cardiovascular Society in Scotland in September. He will present a medical paper entitled "Ischemic Neuropathy in Association with Arteriosclerotic Occlusive Disease" at the meetings. Dr. Nemir presented a paper entitled "Surgical Management of Aneurysms of the Aorta and Great Vessels" at the Continuing Education Program for Florida Physicians held recently in Tallahasse.

The community of Heckscherville recently honored **L. R. Purcell, M.D.,** for 50 years of dedicated service. Among other things, it is estimated that Dr. Purcell has delivered 2,300 babies over that 50 year period. He continues to see patients in his Heckscherville office.

Chan Kun Chung, M.D., Scranton, was recently certified by the American Board of Plastic Surgery. Before coming to the United States, Dr. Chung was chairman and professor in the department of plastic surgery at Hanyang University Hospital in Seoul, Korea.

Frank A. Pantalone, M.D., Greensburg, was recently elected president of the Interstate Orthopedic Society at its meeting in Pittsburgh. Dr. Pantalone was also recently made a fellow of the American Orthopedic Foot Society at the organization's annual meeting in San Francisco.

The DuBois Area Academy of Physicians and Dentists honored the following retiring physicians for their dedicated years of service to the profession and community: **T. C. Klein, M.D.; J. M. Tyson, M.D.; James T. Carlino, M.D.; E. E. Houck, Jr., M.D., and E. F. Getto, M.D.**

Jerome Dunn, M.D., Allentown, and **Irving S. Colcher, M.D.,** Lansdale, were recently elected fellows in the American Academy of Pediatrics during a meeting of the executive board in Denver.

Barry B. Moore, M.D., Harrisburg, has recently been certified by the American Board of Neurological Surgery. He is a member of the Congress of Neurological Surgeons, the Mid-Atlantic Neurosurgical Society, and the South Central Pennsylvania Neurological-Neurosurgical Society.

George J. Thomas, M.D., emeritus professor of anesthesiology at the University of Pittsburgh School of Medicine, recently received the Ralph M. Waters' International Award. The award, which is sponsored by the International Anesthesia Award Commission, was presented at the Midwest Anesthesiology Conference held in Chicago. In the past Dr. Thomas has been the recipient of distinguished service awards from the International Anesthesia Research Society, American Society of Anesthesiologists, and the National Fire Protection Association.

James A. Yates, M.D., assistant plastic surgeon at Harrisburg Hospital, was recently certified by the American Board of Plastic Surgery.

Harry Shubin, M.D., F.A.A.M.A., Philadelphia, was recently elected chairman of the Council of Investor-Owned Hospitals of the Hospital Association of Pennsylvania. Dr. Shubin is medical director of Center City Hospital and adjudication judge for hospitals in the Department of Justice of Pennsylvania.

Vito DelVecchio, M.D., associate professor in biology at the University of Scranton, was recently awarded a National Science Foundation faculty fellowship. He will work with a team of scientists at the General Electric Space Research Laboratory at Valley Forge. Dr. DelVecchio will gather information on the separation and isolation of biological compounds for use in various types of therapy. The information will be used in a forthcoming Skylab project.

Paul G. Bovard, M.D., Fawn Township, was awarded an honorary doctor of science degree by Washington and Jefferson College recently. Dr. Bovard was honored for his contributions to society by practicing medicine and engaging in research on the diagnosis of diseases from x-rays, such as silicosis and bone density due to fluoride absorption.

Alexander M. Minno, M.D., delivered the commencement address at Conemaugh Valley High School in Johnstown recently. Dr. Minno, a graduate of the school, spoke on the topic of changes from liberal arts subjects to the sciences. He is clinical instructor in medicine at the University of Pittsburgh School of Medicine.

Narayan Deshmukh, M.D., Sayre, was certified recently by the American Board of Surgery and the Royal College of Surgeons of Canada. Dr. Deshmukh is assistant professor of surgery at Hahnemann Medical College, Philadelphia.

Six physicians completing three year residencies at Lancaster General Hospital were honored at a recent awards ceremony. **Alan S. Peterson, M.D.**, received the Charles Bair Award for excellence in family practice. **Richard A. Anderson, M.D., James F. Drukenbrod, M.D., Edward M. Fine, M.D., David W. Kistler, M.D.**, and **J. Donald Segrist, M.D.**, were also honored.

Julius Newman, M.D., Narberth, presented a paper on "Defatting the Bulbous Nasal Tip" before the Second International Symposium on Plastic and Reconstructive Surgery of the Head and Neck, sponsored by the American Academy of Facial Plastic and Reconstructive Surgery, held in Chicago recently. Dr. Newman is immediate past president of the Philadelphia Society of Facial Plastic Surgeons.

Doris Gorka Bartuska, M.D., and **Jean Gowing, M.D.**, both of Philadelphia, were recently selected as recipients of the 1975 Alumnae Achievement Awards of the Alumnae Association of the Medical College of Pennsylvania. Dr. Gowing has been associated with the college in various capacities for 48 years, is currently professor emeritus, and active in the Pediatric Group Services. Dr. Gowing is a delegate to the Medical Women's International Association and on the publications committee of the American Medical Women's Association. Dr. Bartuska is associate dean, associate professor of medicine, and director of the division of endocrinology and metabolism at the college. She was named Outstanding Educator of America for 1975.

DR. BARTUSKA

DR. GOWING

You are cordially invited to attend
the Twenty-Seventh Annual State Dinner
of the Pennsylvania Medical Society.
Tuesday evening–October 7, 1975
Host Farm Resort Motel
Lancaster, Pennsylvania

Reception • Dinner • Dancing

- **Installation of the 126th President of the Pennsylvania Medical Society, David S. Masland, M.D.**
- **Presentation of Past President's Medallion to A. Reynolds Crane, M.D., 125th President**
- **Presentation of the Distinguished Service Award to Jonathan E. Rhoads, M.D.**
- **Presentation of State Benjamin Rush Awards**

MDs in the news

Your man in Lemoyne

William C. Ryan, M.D. - Eleventh District

ROBERT L. LAMB
Director of Communications

William C. Ryan, M.D., a board certified neuropsychiatrist from Somerset is the Trustee and Councilor for the Eleventh Councilor District, comprising the counties of Bedford, Cambria, Fayette, Greene, Somerset, and Washington. A past president of the Somerset County Medical Society and a past member of the PMS House of Delegates, Dr. Ryan was elected to the State Society's Board of Trustees in October 1970 to fill the unexpired term of George Bloom, M.D., from Cambria County. Dr. Ryan was re-elected to a full five-year term on the Board in 1971.

Born and raised in California, Dr. Ryan received his undergraduate degree from U.C.L.A. in 1953. He earned his M.D. degree at Georgetown University. He interned at D.C. General Hospital and took his residency in psychiatry at the University of Pittsburgh, Western Psychiatric Institute, 1958-61. Dr. Ryan became board certified in psychiatry in 1963.

Dr. Ryan, his wife, Alice, and their eight children have spent the last 14 years living in Somerset, a town of some 6,000 nestled in the Laurel Highlands of southwestern Pennsylvania. He came to Somerset in 1961 as clinical director of the Somerset State Hospital. In 1964, he became superintendent of the institution, a position he held for nine years until his decision in 1973 to go into private practice. As a trustee and councilor, Dr. Ryan has been particularly interested in the organizational structure of county medical societies and their relationship to other components of the profession. In 1974, he recommended to the House of Delegates that the Committee on Constitution and Bylaws and the Interspecialty Committee prepare a draft of model county society Bylaws which would specifically reflect the needs of organized hospital and other medical staff groups, including provision of a forum for the presentation and resolution of problems of local medical interest. Dr. Ryan also urged each county medical society to review its Bylaws to determine how its structure might better serve institutional groups within organized medicine.

This fall the recommendations will be considered by the House of Delegates when the report of the Committee on Constitution and Bylaws is reviewed.

Dr. Ryan has also urged a review of the dues structure of county medical societies and the manner in which this relates to the priorities of the society. Many times dues assessments are based more on

traditional society social needs than on a review of the current priorities of the society.

Closely related to this concern is Dr. Ryan's emphasis on the need for political action by physicians. In this regard he has advocated increased participation by physicians in the Pennsylvania Medical Political Action Committee. This continues to be a priority concern.

In his private practice in neurology and psychiatry in Somerset, Dr. Ryan is especially interested in the psychosomatic elements of disease. Dr. Ryan works in the Somerset-Bedford Mental Health and Mental Retardation Program. He is a consultant in neurology and psychiatry to the Pennsylvania State Rehabilitation Center in Johnstown and a consultant in forensic psychiatry to the state mental hospital in Somerset. Dr. Ryan provides inpatient care in psychiatry and neurology at the Somerset Community Hospital and provides medical service to the Somerset-Bedford County Drug and Alcohol Program, a program which allows former addicts to help rehabilitate incoming patients in the context of a non-hospital detoxification unit.

Dr. Ryan currently serves on the State Society's Finance Committee and is the Board of Trustees representative to the Pennsylvania Medical Care Foundation Board of Directors. He is also a trustee of the Society's Educational and Scientific Trust.

MDs in the news

Your man in Lemoyne

Orlo G. McCoy, M.D. - Twelfth District

ROBERT R. WEISER
Communications Division

For nearly 30 years Dr. Orlo McCoy, trustee of the Twelfth Councilor District, has been a familiar face in northeastern Pennsylvania, serving both the people and the more than 400 physicians of the Pennsylvania Medical Society who live there.

A native of Smethport in McKean County, Dr. McCoy attended the University of Pittsburgh where he received his B.S. degree in 1937. He graduated from the university's school of medicine, receiving his M.D. in 1940.

A one year internship at Robert Packer Hospital in Sayre introduced him to the section of the state that would later be his home. However, following completion of that training, he returned to the western section of the state to set up practice in Cory in Erie County in 1941. It was then that he first joined organized medicine.

His practice was interrupted abruptly by World War II. Dr. McCoy served for more than three years with the Army Medical Corps in the European Theater of Operations, receiving a bronze star for action at the Battle of Bastogne.

Discharge from the army saw him return not to Cory, but to Sayre where be began a residency in internal medicine at Robert Packer Hospital in 1945. He was anxious to enter his own practice once again and after 14 months left the residency to open a general practice in nearby Canton where he has remained since 1946.

He very quickly became active in organized medicine in Bradford County and was elected president of the Bradford County Medical Society in 1948. Since then his service to organized medicine has been distinguished. He represented his county in the State Society House of Delegates for 25 years and during that time also served as first, second or third vice president of the State Society on several occasions. He has also served on several of the Society's councils, committees and commissions, including the Council on Public Service, the Council on Medical Service, the Committee on Rural Health Care, and the Officers' Conference Committee.

Dr. McCoy was elected trustee of the Twelfth Councilor District in October 1971. He represents the physicians of Bradford, Luzerne, Sullivan, Susquehanna, and Wyoming Counties.

Dr. McCoy is also a member of the American Academy of Family Physicians and a diplomate of the National Board of Medical Examiners.

Active in civic affairs, Dr. McCoy serves as school physician for the Canton Area District Schools. He is an elder of the First Presbyterian Church of Canton, a member of the Rotary Club and a 32nd Degree Mason in the Canton Lodge F&AM, as well as a member of the Valley of Coundersport Consistory.

editorials

Compassion - essential to practice of medicine

On Friday, June 6, 1975, an editorial by Judah Folkman, M.D. appeared in the *New York Times* entitled "For Doctors, A Little Practice Is A Dangerous Thing." The idea he presented and expanded upon was that physicians do not merely learn while they are in residency training, but continue to learn by trial and error as long as they are taking care of patients. He explains that a good clinician is good because he has acquired his judgement and skill the hard way, hence the "practice" of medicine. In conclusion, Dr. Folkman submits, among other things, that compassion for the patient is a very important element in medicine.

In 1929, Joseph W. Krutch observed in his book, *The Modern Temper,* that modern science possesses a spiritual iconoclasm in which man attempts to explain away emotional experience and further that science as an intellectual pursuit of metabolism and hormones, rational and monotonous, does little to accommodate human needs. Samuel Harrison Smith viewed science in much the same way in 1798 in his *Remarks on Education.* "All science ought to derive its rank from utility. The real good which it derives, actually does, or is capable of doing, is the only criterion of its value."

The basic difference in these philosophies is the primary dilemma of the medical world. Medicine and medical science, although closely related and certainly interdependent, are not by definition the same thing. Medicine is a broad discipline which combines scientific foundations and modern innovation with human physical and emotional needs in an attempt to heal the sick. Medical science is just that—logical, unemotional, and intellectual. Medical science has made vast strides in the past fifty years but medicine has failed to keep pace on the human side, and this imbalance has threatened to destroy the private practice of medicine as we know it.

Science moves forward at a rather regular rate, building and expanding on data accumulated for centuries. Society, on the other hand, tends to move at variable rates from calm to crisis and back again. Thus we moved from Roosevelt's New Deal to the calm of the Eisenhower era and on to the social upheaval of the Kennedy-Johnson years. Medicine has not been isolated from social problems. Critics have claimed that there is a "doctor shortage" and that there are "too many doctors" at the same time. Both assertions are half correct. The real problem is maldistribution of the physician population in the ghetto-urban-rural areas. The decline of the country doctor has paralleled the urban-suburban movement of our population, so that there is a shortage in the rural areas and a plethora in the cities.

In keeping with the scientific advancements in the pathological disease mechanisms and given physician concentrations of the proportion found in cities, superspecialization has resulted. There is nothing wrong with specialized practice of medicine but, unfortunately, it tends to focus upon *diseases* rather than *people* who are ill. Not only does the patient find it difficult to discover a portal of entry to the system, but when he does, he is treated as an academic disease and not a personality. Alienation of some degree must result from this sort of arrangement and is evidenced by the breakdown in

Supplemental Call to the 1975 Annual Session Pennsylvania Medical Society House of Delegates

As directed by Article IX, Section 5 of the Constitution, the Board of Trustees nominate the following members for vacancies on the Judicial Council: For the office now held by Russell B. Roth, M.D., the Board nominates Russell B. Roth, M.D., Erie County; Arthur J. Patterson, M.D., Greene County; and Sydney E. Sinclair, M.D., Lycoming County.

For the office now held by George E. Farrar, Jr., M.D., the Board nominates Charles A. Bikle, M.D., Franklin County; Stephen J. Deichelmann, M.D., Montgomery County; and George E. Farrar, Jr., M.D., Philadelphia County.

the physician-patient relationship. And who can blame the patient?

Solutions to these problems are not easily defined and when defined are not easily implemented. Many medical schools have recognized the dearth of primary physicians and have created training programs in family and community medicine. The re-creation or resurrection of the family practitioner will partially ease some of the problem. It will provide patients with a main physician, access to the medical system and a referral base. It will help to create a more workable balance of specialists and primary care physicians, which is a desirable goal. It will not, in itself, solve the distribution problem and if an answer is not soon found for this, the government threatens to do so with legislation currently before Congress.

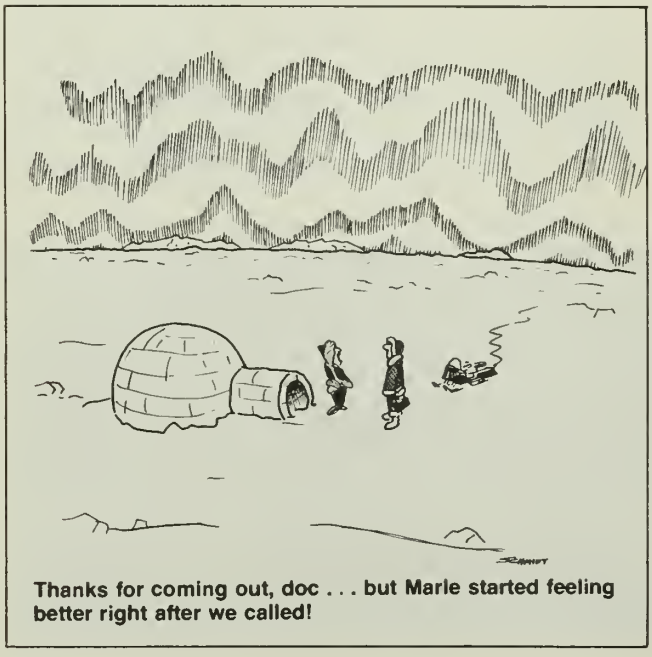
The problems we face in medicine are intricate and disquieting, but they are not unsolvable. Medical science has provided us the technique with which to treat the disease. Now it remains for the physician to treat the patient with the compassion and understanding that the phrase "practice of medicine" implies.

David A. Smith, M.D.
Medical Editor

A call for support

It should be obvious to all of us physicians by now that our active involvement in the political process is an absolute necessity. Major decisions affecting the delivery of health care are being made almost daily in Harrisburg and Washington by elected officials and bureaucrats with little or no first hand understanding of the practice of medicine. It is vitally important that physicians, who are the experts in caring for the sick, have an active and meaningful role in this decision-making process.

It is also vitally important that physicians fulfill their duty as citizens by active participation in the selection process which determines who makes the laws. It is necessary to support good legislative candidates before they are elected in order to insure a sympathetic ear afterwards, where issues vital to the free practice of medicine are being considered. It has been said by someone wise in the ways of politics that "legislation is made in the voting booth on election day, and not in legislative session." As we have seen in the recent past, this is often true!



Thanks for coming out, doc . . . but Marie started feeling better right after we called!

Physicians and other professionals in health care have a vehicle for effective political action in the Political Action Committee (PAC). This organization, which had many of its roots in Pennsylvania, received official sanction as the physicians' political arm with the founding of AMPAC, the American Medical Political Action Committee, in 1962. The PAC organization offers physicians an opportunity for organized, unified political activity and magnifies the effectiveness of individual physician efforts. The PAC organization has as its goals three main objectives:

1) Education of physicians in the political process;
2) Active involvement of physicians in the political process;
3) Financial support of responsible candidates of both parties, who will give physicians' views a fair hearing on health related issues.

Thomas Jefferson once said, "When things in government go so far wrong as to attract the public's attention, they (the public) may be relied upon to set them to rights." With the current issues before us, national health insurance, the malpractice crisis, and oppressive health planning legislation, it should not require a 2x4 between the eyes to convince physicians that things indeed are going "far wrong." Citizens of our state and our country are relying on us to help set them to rights.

I strongly urge your support of and participation in PaMPAC and AMPAC.

Michael P. Levis, M.D., President
Allegheny County Medical Society

(Reprinted from The Bulletin of the Allegheny County Medical Society)

ROCHE

IMPORTANT

AME CHANGE ANNOUNCEMENT

Larotid™
(amoxicillin)
is the
new name for
Larocin
(amoxicillin)
the oral broad
spectrum antibiotic
from Roche

Please see last page of this advertisement for a summary of product information.

Larotid™ (amoxicillin) is the new name for Larocin

Roche Laboratories has received several reports concerning the possibility of confusion between written prescriptions for Larocin (amoxicillin) and Lanoxin, a brand of digoxin from Burroughs Wellcome Co. While the potential for dispensing errors appears to be quite low, we have, nevertheless, decided to change the name of our product to LAROTID™ (amoxicillin).

Please be assured that the safety and effectiveness of the product itself are not in question. For this reason, pharmacists may continue to dispense Larocin until inventories are exhausted. As soon as possible, all packaging leaving Roche distribution centers will carry the new name, LAROTID.

We know you will agree that this action is in the best interest of your patients. If you have any questions about the name change, contact us directly at (201) 235-2357, or through your Roche representative. Before prescribing LAROTID, please consult the complete product information, a summary of which appears at the right.

ROCHE

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Infections due to susceptible strains of the following gram-negative organisms: *H. influenzae, E. coli, P. mirabilis* and *N. gonorrhoeae;* and gram-positive organisms: streptococci (including *Streptococcus faecalis*), *D. pneumoniae* and non-penicillinase-producing staphylococci. Therapy may be instituted prior to obtaining results from bacteriological and susceptibility studies to determine causative organisms and susceptibility to amoxicillin.

Contraindications: In individuals with history of allergic reaction to penicillins.

WARNINGS: SERIOUS AND OCCASIONALLY FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS REPORTED IN PATIENTS ON PENICILLIN THERAPY. ALTHOUGH MORE FREQUENT FOLLOWING PARENTERAL THERAPY, ANAPHYLAXIS HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. MORE LIKELY IN INDIVIDUALS WITH HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. BEFORE THERAPY, INQUIRE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS OR OTHER ALLERGENS. IF ALLERGIC REACTION OCCURS, INSTITUTE APPROPRIATE THERAPY AND CONSIDER DISCONTINUANCE OF AMOXICILLIN. **SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. ADMINISTER OXYGEN, INTRAVENOUS STEROIDS AND AIRWAY MANAGEMENT, INCLUDING INTUBATION, AS INDICATED.**

Usage in Pregnancy: Safety in pregnancy not established.

Precautions: As with any potent drug, assess renal, hepatic and hematopoietic function periodically during prolonged therapy. Keep in mind possibility of superinfections with mycotic or bacterial pathogens; if they occur, discontinue drug and/or institute appropriate therapy.

Adverse Reactions: As with other penicillins, untoward reactions will likely be essentially limited to sensitivity phenomena and more likely occur in individuals previously demonstrating penicillin hypersensitivity and those with history of allergy, asthma, hay fever or urticaria. Adverse reactions reported as associated with use of penicillins: *Gastrointestinal:* Nausea, vomiting, diarrhea. *Hypersensitivity Reactions:* Erythematous maculopapular rashes, urticaria. *NOTE:* Urticaria, other skin rashes and serum sickness-like reactions may be controlled with antihistamines and, if necessary, systemic corticosteroids. Discontinue amoxicillin unless condition is believed to be life-threatening and amenable only to amoxicillin therapy. *Liver:* Moderate rise in SGOT noted, but significance unknown. *Hemic and Lymphatic Systems:* Anemia, thrombocytopenia, thrombocytopenic purpura, eosinophilia, leukopenia, agranulocytosis. All are usually reversible on discontinuation of therapy and believed to be hypersensitivity phenomena.

Dosage: *Ear, nose, throat, genitourinary tract, skin and soft tissue infections*—Adults: 250 mg every 8 hours. Children: 20 mg/kg/day in divided doses every 8 hours; under 6 kg, 0.5 ml of Pediatric Drops every 8 hours; 6-8 kg, 1 ml of Pediatric Drops every 8 hours. *Lower respiratory tract infections and severe infections or those caused by less susceptible organisms*—Adults: 500 mg every 8 hours. Children: 40 mg/kg/day in divided doses every 8 hours; under 6 kg, 1 ml of Pediatric Drops every 8 hours; 6-8 kg, 2 ml of Pediatric Drops every 8 hours. *Gonorrhea* (acute uncomplicated anogenital and urethral infections)—Males and females: 3 grams as a single oral dose. *NOTE:* Children weighing more than 8 kg should receive appropriate dose of oral suspension 125 mg or 250 mg/5 ml. Children weighing 20 kg or more should be dosed according to adult recommendations.

Note: In gonorrhea with suspected lesion of syphilis, perform dark-field examinations before amoxicillin therapy and monthly serological tests for at least four months. In chronic urinary tract infections, frequent bacteriological and clinical appraisals are necessary. Smaller than recommended doses should not be used. In stubborn infections, several weeks' therapy may be required. Except for gonorrhea, continue treatment for a minimum of 48-72 hours after patient is asymptomatic or bacterial eradication is evidenced. Treat hemolytic streptococcal infections for at least 10 days to prevent acute rheumatic fever or glomerulonephritis.

Supplied: Amoxicillin as the trihydrate: Capsules, 250 mg and 500 mg; oral suspension, 125 mg/5 ml and 250 mg/5 ml; pediatric drops, 50 mg/ml.

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Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

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2. sign it and **be sure** that your **name**, **address** and medical education number **appear on** the **application** (or report) itself.
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5. **mail** directly **to:**
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*Choloxin®
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An agent for low density lipoproteins, "type II hyperlipidemia," in euthyroid, non-cardiac patients.

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See reverse side for full prescribing information

Choloxin® (sodium dextrothyroxine)

The Lipid-Lowering Agent with Once-A-Day Dosage

Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic endproducts do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

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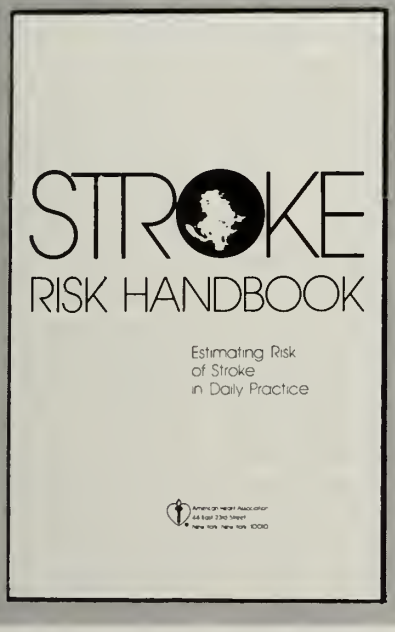

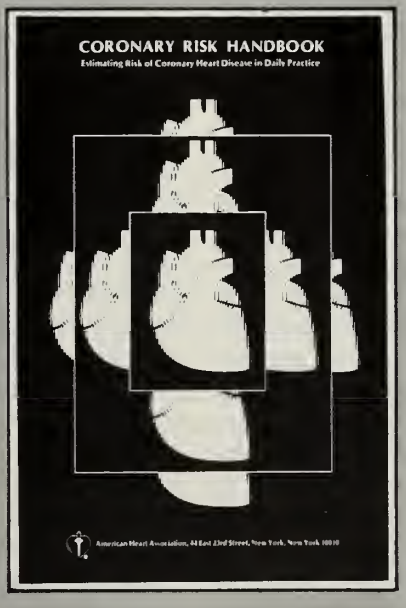

Materials Available From The Heart Association

Two Risk Handbooks for physicians are available from Chapters of the American Heart Association to help estimate the risk of stroke and coronary artery disease in patients.

In both books, the degree of risk is estimated from probability tables using seven factors frequently measured in office practice. The tables are based on an epidemiological study by the U.S. Public Health Service, using long-term data from the Framingham Study. A risk assessment and management form is included in each book.

For a copy of the Risk Handbooks, contact your local Chapter of the American Heart Association, Pennsylvania Affiliate, P.O. Box 2435, Harrisburg, Pennsylvania 17105.

Hahnemann establishes third satellite campus

In an effort to relieve the Lehigh Valley's physician shortage, Hahnemann Medical College and Hospital, Philadelphia, Lehigh University, Bethlehem, Easton Hospital, and Muhlenberg Hospital have agreed to establish a six year, B.S.-M.D. family medicine training program. The agreement provides for the training of specially chosen Lehigh Valley students who intend to return to their home towns, where there are physician shortages, to practice family medicine after graduation.

By setting up "satellite campuses" in areas where doctors are most needed, Hahnemann hopes to end scarcity in the smaller communities of the Lehigh Valley. Similar programs already link Hahnemann with Wilkes College, Wilkes-Barre, and Gannon College, Erie.

These joint educational ventures bring together the local college which contributes two years of premedical training to the specially designed six year course of study, Hahnemann, where two years of medical courses are taken, and one or more hometown hospitals which provide clinical training for the final two years. The participating students spend four of the six years in their communities while learning under a custom made curriculum and seeing first hand the practice of family medicine.

State plans health care center for seniors

Plans for the Pine Run Health Care Center were approved recently by the Pennsylvania Health Department, Department of Labor and Industry, and Doylestown Township. The health care center is being built as part of the 100 acre Pine Run lakeside village in Doylestown for people 65 and older.

The costs of using the facilities are included in trust fund payments which Pine Run residents make for unlimited, lifetime health services. Non-residents of the center may also use the facilities on a fee for service basis.

The center will include facilities specifically designed for the ambulatory confused and self-care patients. Patients will be encouraged to have their own furniture and mementoes. Nurses will dress in street clothes and the dining room will have waitress service. These innovations are designed to help patients retain a sense of self which is often lost in such an institution.

The community provides residents with unlimited lifetime medical, surgical, hospital, and nursing care in return for a one-time fixed payment in trust and a monthly service fee. The trust fund payment is earned by the community over a nine year period and is refundable, on a pro-rated basis, to residents who decide to leave within the first nine years.

Completion of the Pine Run Health Care Center is scheduled for January 1976.

QUESTIONS? SUGGESTIONS!
are invited for consideration by
The Committee on Objectives
Pennsylvania Medical Society

_____
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_____
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_____
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Send to:
Committee on Objectives
Pennsylvania Medical Society
Box 301, Lemoyne, PA 17043

Acupuncture

DANIEL J. MENNITI, Ph.D., J.D.
Harrisburg

The continuing saga of the place of acupuncture vis-a-vis the practice of medicine in the Commonwealth of Pennsylvania advanced another chapter in the Court of Common Pleas of Philadelphia County on April 17, 1975. Judge Cavanaugh concluded, in general, that the practice of acupuncture was encompassed in the Medical Practice Act and that, therefore, those not licensed to practice medicine in the Commonwealth of Pennsylvania are forbidden to practice acupuncture.

Terming acupuncture as "an exotic modality of treatment," the judge relied for his conclusions on the definition of medicine and surgery as defined in the Medical Practice Act of 1973. The court, however, also looked to the testimony of experts in the field to determine the exact nature of the practice of acupuncture so that its relationship to the Medical Practice Act could be defined in practical terms.

The court ultimately held that the Medical Practice Act concerns itself with "the acceptance and regulation of modalities affecting the health, safety and welfare of the citizens of the Commonwealth" and since acupuncture, as practiced, affected the health and safety of citizens, it fell within the ambit of the Medical Practice Act.

The author is associated with the law firm of Pepper, Hamilton, and Scheetz, which provides legal counsel to the State Society.

Defendants argued that acupuncture could be classed with other nonmedical activities, such as tatooing, paramedical procedures, electrolysis, and so forth. The court held that the questions of law and fact were "inextricably involved" and that the factual and legal situations had to be resolved together in the light of the Medical Practice Act and its purpose.

The court gave great weight to the testimony of experts who responded to hypothetical situations. The court did say, however, that "we independently conclude that the specific activities of each non-licensed defendant in inserting, manipulating, and withdrawing needles constituted the practice of medicine as prescribed by the Commonwealth." Ultimately the court refuted the idea of the defendants that acupuncture is outside the ambit of the Medical Practice Act, and held:

> To accept defendants' position that acupuncture is neither contemplated by the Act nor a science in the ordinary sense, would result in an unnatural circumscription of a legislatively mandated objective that is undeniably vital to the protection and promotion of the welfare of the citizens of this Commonwealth. The simple contemplation of a Medical Practice Act is to proscribe the unlicensed practice of medical and medically-related acts, regardless of their technical appellation or plan or origin, irrespective of their manner of treatment, so long as the application of those acts concerns the cure of disease, preservation of health, or the treatment of ailments.

It is interesting to note that in the findings of fact the court decided that the potential dangers in the practice of acupuncture by one who is not licensed as a physician include: "(a) the inability to screen for and respond to potential dangers and contingencies such as infections, hemorrhage, etc.; (b) the inability to manage sudden emergencies; (c) the inability to make diagnoses with respect to ailments and their manifestations of pain; and (d) the inability to alter medical procedures to meet the patient's needs, welfare and safety."

The court did note, however, in its conclusions of law that there is no specific or explicit statutory regulation or licensing act which controls the practice of acupuncture in Pennsylvania. But the court also noted that there is risk of irreparable harm and injury if the persons who are unlicensed to practice medicine are permitted to continue the practice of acupuncture in Pennsylvania. The court also stated that there is no violation of equal protection of laws in enjoining the defendants from the practice of acupuncture.

The court in its decision, therefore, stamped a firm approval for the conclusion of the opinion of the Attorney General dated July 23, 1974, in which Mr. Packel stated that "only doctors of medicine and osteopathy may practice acupuncture subject to the limitations imposed by their respective licensing board."

Pittsburgh group progresses toward gonorrhea vaccine

A group of researchers, led by Charles C. Brinton, Jr., Ph.D., a professor of microbiology at the University of Pittsburgh, has made recent progress toward the development of a vaccine against gonorrhea and a corresponding blood test for the disease. Professor Brinton announced the advance at the 75th annual meeting of the American Society for Microbiology in New York.

Dr. Brinton said that the research group had isolated a derivative of *N. gonorrhoeae*. There are four known types of the bacteria, two of which cause the disease. The cells of these two have pili projecting from the main body. Using more than 20 virulent strains, the researchers isolated the pili from the main bodies of the *N. gonorrhoeae* cells. The material isolated was in the form of rods of single pili and crystals of aggregated pili. Unattached, the pili cannot cause the disease but do cause the body to produce antibodies.

Dr. Brinton and another researcher gave the vaccine to themselves. Then the two researchers, along with three other university faculty members who had not been immunized, were exposed to gonorrhea. Dosage levels of the bacteria were raised until all five showed evidence of the disease. They all were immediately treated with antibiotics.

The level of protection for the two who had received the vaccine was about 60 percent higher than for the other three. Present estimates are that the chances of contracting gonorrhea are 30 percent per contact. The vaccine may lower the chances to 1 percent per contact.

When mixed with the blood serum of persons who have developed gonorrhea antibodies, the pilic material forms clumps which are visible through a conventional microscope. Such a test would be much simpler and less time consuming than present tests. However, the test has two weak points: it cannot detect the presence of gonorrhea until the body has been exposed to the bacteria for one week since it takes that long to produce antibodies; and since the antibodies are long lasting, the test cannot distinguish those who have the disease from those who had contracted it but are now disease free. Dr. Brinton says that the test could be used in mass public health screening.

Other researchers participating in the project were Kenneth Rogers, M.D., chairman of the department of community medicine in the school of medicine; John McMichael, Ph.D., research associate in the department of biophysics and microbiology; Chuen-mo To, Ph.D., research assistant professor and electron microscopist in biophysics and microbiology; and Jo-Anne Dillon, Ph.D., and Linda Jacobson, Ph.D., research associates.

Cooperating in clinical and animal studies were Richard Michaels, M.D., professor of pediatrics at Pitt's medical school; Stephen Krauss, M.D., of the Center for Disease Control in Atlanta; and Joseph Sarandria, chief of the Allegheny County Health Laboratories.

Wills to hold conference

The Retina Service of Wills Eye Hospital and Jefferson Medical College of Thomas Jefferson University are cosponsoring their seventh annual conference, a comprehensive course on "Vascular Diseases of the Ocular Fundus." It will be held March 6 and 7, 1976, at Jefferson Hall Commons in Philadelphia.

The course will cover: anatomy; physiology; pharmacology; fluoroangiography; disorders of the vessels and blood constituents; maculopathies; vascular tumors; anomalous vascular formations; medical and surgical concepts; and oculocerebral problems.

Tuition will be $175 with a special rate of $60 for residents and fellows. Lunches and a dinner are included. The course is approved for 13 hours of Category I credit towards the Physician's Recognition Award of the American Medical Association.

For further information, hotel reservations, and wives' Bicentennial activities, write Richard E. Goldberg, M.D., Retina Service, Wills Eye Hospital, 1601 Spring Garden Street, Philadelphia, PA 19130.

Rectal surgeons meet

The Pennsylvania Society of Colon and Rectal Surgery will hold its scientific meeting Wednesday, November 5 at the Host Inn, Harrisburg.

The program will be presented in three segments: colonoscopy and polypectomy; granulomatous and ulcerative colitis, and hemorrhoidectomy—which technique and why. Experts will present papers on various topics and panel discussions will follow the main segments of the program.

The program will begin Wednesday at 11:00 a.m. with opening remarks by Josiah C. McCracken, M.D., president, and end at 5:20 p.m. For more information contact Indru T. Khubchandani, M.D., Liberty Square Medical Center, 17th and Liberty Sts., Allentown, PA 18104.

Hawaii tour available to State Society members

Society members and their families will be able to tour Hawaii in conjunction with the American Medical Association Clinical Convention to be held November 30 to December 3 in Honolulu. The tour, arranged through Group Travel Unlimited (GTU) of Chicago, is set for November 28 through December 9.

From November 28 to December 4 tour participants will be on the island of Oahu where they will take a Pearl Harbor cruise. Superior accomodations will be available at the Hilton Hawaian Village in Honolulu.

From December 4 to December 9 tour participants will be on the island of Kauai where they will tour Waimea Canyon and take a Wailua river boat cruise. Superior accomodations will be available at the Kauai Surf Hotel. Departure from Honolulu will be on December 9 although tour participants may arrive home on December 10 due to time zone changes and time of flight departures.

On both islands tour desks will be set up in hotel lobbies for side trips at additional expense to members.

No deviation from the package, which is offered at group rates, is permissible. All bookings must be made through GTU, which was designated by the AMA to handle all travel arrangements. A flyer, which has been published in this issue and previous issues, features a coupon which should be used to book your tour. Contact Miss Joselyn Loy at PMS headquarters to request additional flyers.

GTU offers other tours and is able to arrange individualized tours. Contact GTU at (800) 621-1046 to answer your questions about the tour for PMS members or other tours.

Please refer to the published flyer, which describes rates including round trip jet fair, taxes, and services. Cancellation and refund policies are also explained.

Temple announces course

Temple University is sponsoring a ten week course entitled "Behavioral Techniques for the General Practitioner," which is designed to teach general practitioners how to handle patients' complaints which have either a purely psychological basis or an organic basis amplified by psychological factors. An understanding of behavioral principles and techniques can aid the physician in alleviating both the physical and psychological distress and in alternating maladaptive behavior. Among the scheduled topics are relaxation techniques, psychosomatic disorders, sexual dysfunction, and phobias.

The course will begin Wednesday, September 17, 2:00-4:00 p.m. The fee is $250. For more information contact Ms. B. J. Foster, Behavior Therapy Unit, Temple University Department of Psychiatry, c/o E.P.P.I., Henry Ave. and Abbottsford Rd., Philadelphia, PA 19129; (215) 438-4298, x54.

Duty sharing planned

The Pennsylvania Department of Health and the Philadelphia Regional Food and Drug Administration have signed an agreement allowing them to share inspection duties for Pennsylvania drug, device, and cosmetic establishments. The agreement makes Pennsylvania the second state in the nation to participate in the sharing of inspections, drug emergencies, medical device quackery, and open exchange of information with the FDA, and is expected to give greater protection to the Pennsylvania consumer.

Pennsylvania Secretary of Health Leonard Bachman, M.D., and several FDA officials were present for the signing of the agreement. Jack B. Ogun, chief of the drug, device, and cosmetic compliance section of the Department of Health, will be responsible for coordinating activities with FDA personnel.

MCP offers retraining

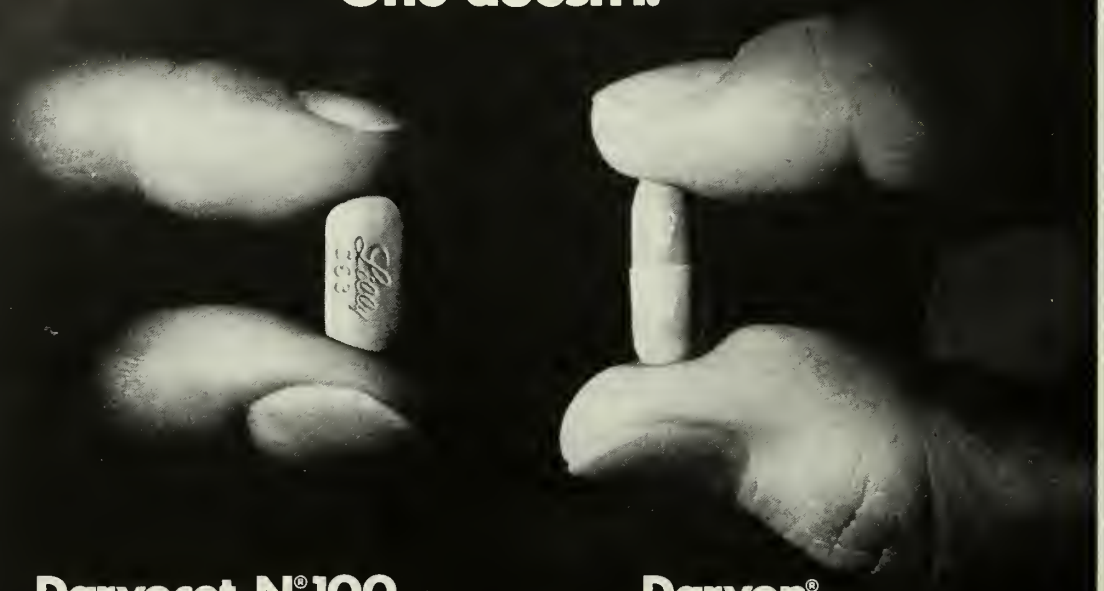
The Medical College of Pennsylvania is accepting applications for the fall 1975 session of the eight week Retraining Program for Inactive Physicians. The program provides clinical training for inactive physicians who wish to re-enter clinical medicine by offering review of physical diagnostic skills, experience in clinical rotations and a lecture series on general medicine, pathophysiology, diagnosis, and patient management.

So far the program has retrained over seventy women and men physicians. Almost all have returned to active medicine, either as residents or practitioners. The program is expected to be held twice yearly for at least the next two years.

The deadline for applications for the fall session is September 1. The application deadline for the spring 1976 session is March 1, 1976.

For an application and additional information contact: Retraining Program, Center for Women in Medicine, The Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia, PA 19129.

One contains aspirin. One doesn't.



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practice management

Selecting and obtaining the best office

LEIF C. BECK, LL.B.

VASILIOS J. KALOGREDIS, J.D.

Bala Cynwyd

This is the first of two articles dealing with the selection and acquisition of the most appropriate office by a medical practice. We consider that good physical office space is essential to efficient practice, while its cost may be one of the few truly fixed items in an otherwise inflationary overhead. We hope these guidelines will help any physician or group critically evaluating their present office or considering relocation.

Flexibility—the key word

The selection of an office is important simply because it will probably have a fairly *long term* effect. If the space is to be rented, the lease may run for three, five, or even ten years. If it is to be purchased outright or constructed by the doctor it will probably not be changed for many more years than that. Hence, an office selection which turns out to be unfortunate might not easily be corrected and may prove to be costly.

The single most important consideration in obtaining an office is *"flexibility."* For physicians entering into practice anew, practice patterns and growth are not yet known. Therefore, the office should be capable of accommodating spectacular growth in volume, additional physicians and/or other employees, changes in office routines and the like. The opportunity even to move out and relocate at a more effective space is an excellent item of flexibility.

The existing practice should similarly remember the need to avoid becoming "boxed into" its present circumstances. Particularly because practices tend to increase in number of physicians and staff over the years (even in many cases where the doctors had previously sworn it would never happen to them), a present office might in time become too small. Furthermore, hospital affiliations, community patterns, and even the doctors' own personal circumstances may change enough in future years that the immovable office can become a restraint on otherwise sensible decisions (from both an efficiency and financial point of view).

Throughout these articles, therefore, retaining maximum *flexibility* should be uppermost in the doctors' minds.

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.

Locating the office

Deciding where the office should be located involves some considerations that tend not to vary among the specialties as much as may first be assumed. They include the following:

Practice at home—Locating one's office in a portion of his home may be one of the worst mistakes a physician can make. This tends to be so even if the doctor should locate or build a home with an office affixed so it arguably permits separation of his personal and professional lives.

As a matter of pure economics, a combination home and office is extremely risky. How many potential buyers might there be for any such real estate? Only that rare combination of family that *both* wants to live in the specific home and has a member needing the office characteristics designed for the original practice. With such a small "resale market," the odds of being able to avoid loss upon changing either one's home or one's practice become far greater than normal.

Many home offices are under special zoning laws permitting only the owner to practice in the office portion—and only if he resides in the home portion. As a result, both the doctor and his family may lose flexibility. The family must stay in the house so long as the practice is to remain there, and vice versa.

Perhaps even more importantly, a home office tends to become a very difficult factor if and when the doctor should take on a partner. Doctors who initially thought they would never do so have later found it desirable to attract at least one partner. Therefore, almost no one should simply assume he will always practice "solo." Partnerships practicing in one doctor's home simply tend to face overwhelming problems of becoming fully compatible. The idea that the resident partner dominates the practice is almost impossible to dispel; the concern over continuation if that partner should die or retire is difficult to handle fairly. Yet for a physician to abandon his home office to accommodate a need for good joint practice at a "neutral" location may be both personally and financially painful.

What is perhaps still more important, though undoub-

tedly an overgeneralization, home practices seem to be the most insulated from professional development. Doctors practicing at home may have the least peer involvement, lacking the communications of active hospital practice and/or a busy medical office building. In our view, the home office tends too unfortunately towards a doctor's (and especially a primary care doctor's) withdrawal from communication with and professional stimulation by his peers.

Convenience to hospital—The trend of almost all medicine is strongly towards hospital orientation. Hence, for any physician to locate his office more than a few minutes away from the hospital is usually a bad choice.

All those specialties involving any degree of hospital practice, from every form of surgery to internal medicine and even to pediatrics, should recognize the time saving aspects of locating office practice as close as possible to the hospital. It simply increases efficiency by cutting down on the transportation time, which can be devoted to more office patients, higher income or more free time. As an example, saving just fifteen minutes per trip by locating one's practice in a hospital's own medical building could add three to six office visits per day and $5,000 to $10,000 gross income per year—or it could cut a half hour to a full hour off one's working day. By being more accessible, many such physicians also find their hospital work increases due to increased referrals and strong patient identity as an "X Hospital" practice.

Proximity to the hospital may not be as essential to some types of practices. For example, family practices may refer its hospitalized patients to other specialists, although most of them prefer (properly in our view) to retain at least some hospital work for the professional stimulation it offers. Psychiatrists, dermatologists, allergists, and many pediatricians may have almost no hospital involvement. Even these physicians should, however, recognize that the clustering of doctors tends to be around the hospital. Maintaining one's exposure to his peers, both for referral purposes and general professional communication, should be a strong factor in preferring hospital proximity.

Particularly if a group of doctors should build its own medical office building, location anywhere but adjacent to the hospital tremendously increases the economic risk. There are simply too many examples of offices originally devoted to "medical arts" losing tenants as they moved closer to their hospital for efficiency and convenience. As the building owners struggle to find nonmedical replacement tenants, the building's rental income and resale value will almost surely decline.

Convenience to patients—It may seem self evident that the office should be reasonably convenient for patients to reach, out of consideration for both their welfare and the practice's growth.

Convenience to the patients does not, however, require location right where they live. First of all, most doctors will either have or want to serve at least several residential areas. Secondly, most patients are used to having to travel some distance for services from other health care providers, so they will find it most convenient if those services are clustered.

Although access to public transportation can be a pos tive factor, it is probably overemphasized. Most patients i almost all economic circumstances are brought to thei doctors' offices by automobile. Traffic patterns and con venience to major roads are thus of far more importanc than are bus, trolley or subway stops. The major exceptio to this conclusion would, of course, be the heavily urba areas—the center city and the "inner city" of a majo metropolis—in which auto transportation is not feasibl and adequate parking may not be available. Even in these situations, however, it is surprising how many patients come to the office by automobile despite intolerable traf fic and parking conditions.

The medical office complex—All the factors discussed above lead to a preference for locating in an office building or an office campus devoted solely to health care providers. Such a complex should, as a matter of its owners' economics, be as near the hospital as possible. It will house a number of physicians (and possibly dentists, opticians, pharmacists, etc.) and will hopefully become a familiar and convenient place for the patients to visit for their health care needs.

A medical office complex has other advantages to the physician establishing or moving his office. First, the intangible imparting of an "image" of quality to patients, other physicians, and oneself. It causes some degree of identification among the doctors practicing in the same building, which should be of some value to each individual. This factor alone is a strong reason for the incoming doctor to be extremely critical of who already occupies that building or campus before he signs his lease.

Second, the other tenants of such a complex may develop common bonds and communications which lead to referrals among them. This factor can, however, be oversold to a prospective tenant who should be careful not to assume that location alone will result in referrals. At any rate, referral patterns within a building may develop even though they can obviously not be assured.

Medical office buildings are likely to already have the proper plumbing provisions, temperature zone variations, and other features unique to medical practice. Commercial buildings have in many cases been found lacking in these areas, often after a doctor has moved in and expended large sums to repair such deficiencies. Any prospective tenant should, however, be sure to canvass the other physicians in the building to learn their experiences with both the building and the landlord. Being of the same profession and probably on the same hospital staff, this communication should be relatively simple and dependable. Care should be exercised, of course, to determine whether some of the physicians consulted are in fact the owners themselves, in which case their opinions might be flavored by their need for the rental.

Requirements of a good office

Since poor office facilities are one of the possible causes of practice inefficiency and chances for immediate change are often negligible, attention to a prospective office's features becomes extremely important. Furthermore, the features must fit the practice when it has expanded or otherwise changed *in the future* (at least

during the lease term) as well as when initially considered. This calls for some candid projections as to the practice's *possible* changes—which may be in several different possible directions—with discipline in applying them to potential offices.

Amount of space needed—Selecting too small an office may be the biggest single management mistake a new physician can make. It is understandable, for the person will feel the pressure of saving rental costs especially since his then small practice requires such little space. In truth, however, office rent is the one expense item which will not increase as the volume of activity increases; it will become "cheaper" (percentage-wise) as the practice grows. A young physician should thus recognize that a generous office space will be his best investment, even if that space is more than presently needed.

Older practices relocating their facilities must recognize the same principle. There must be enough square feet of space to assure *flexibility* for the future. While applicable to rental arrangements, the principle becomes of absolute importance if the group plans to invest its members' own money and credit into the construction of their own building.

Space requirements will obviously vary from practice to practice. An average figure might be 1,000 square feet for one doctor (more if heavily primary care oriented), with slightly declining amounts for additional doctor-members: perhaps 1,800 square feet for two doctors; 2,500 for three; and levelling off at an additional 700 square feet per additional doctor. But any estimate is such an overgeneralization that it should certainly not be relied upon as more than an opener!

One can only responsibly estimate his square footage needs by actually listing his office requirements (present and future) and then attempting to lay them out onto a plan of any proposed space. If those requirements cannot be *comfortably* accommodated, the space is not satisfactory. Some guide as to the various requirements is provided below.

Cost of the space—The per square foot cost of renting desirable space can vary tremendously and nevertheless be acceptable. In one location the rent might be $3 or $4 per square foot while in other places it might be as high as $15. Each might be a bargain for the specific people and location involved if it is the "right" space for most effective practice.

Rental costs are typically stated "per square foot." Calculation is fairly simple, dividing the total rent to be paid in a year (monthly rent times twelve) by the number of *useable* square feet to be leased. One must, however, be alert to assure that the owner or his agent has excluded space for common hallways, stairways, and elevators from his recital of the square foot rental. Thus, the doctor should make his own calculation to check the owner's or agent's sales statements.

Many rentals include the owner's payment of electric, water, sewer, maintenance and janitorial costs, but other arrangements require the tenant-physician to pay some or all of these items. Simply comparing two possible landlord's square foot rental figures may be like "comparing apples and oranges" unless the doctor identifies what is and is not included. Reasonable estimates of any such items which must be paid by the doctor as tenant should be *added* to any rental deal not including them. Then the result can be a comparison of the *total cost* of maintaining each possible office on a per useable square foot basis.

Although square foot costs tend to be the common denominator for leasing comparisons, there is possibly a more important criterion. It is the percentage which total rental costs will bear to the practice's annual gross income. Most effective practices will average occupancy costs from 5 percent to 8 percent of their gross income, with percentages much below or above those figures suggesting unusual and possibly improper use of space. However, the ratio must be geared to the practice's anticipated volume and income, which may be far higher than at the onset of the lease. A new doctor might find his rental costs to be 20 percent or more of his gross income until his practice grows to the volume of similar doctors in his selected area. That would, however, be far more acceptable than for his rental costs to decline to 2 percent of gross in an office too small to handle his rapidly expanding practice with two years still left on his lease term.

Practices building or purchasing their own office space should apply the same mathematics as should those who are renting. Those owner-doctors are in effect leasing from themselves. The per square foot rental cost can be calculated as though the doctors were unrelated, including a reasonable return on the doctors' investing their own funds (which exercise will be discussed in next month's article). The failure to critically determine a prospective owner's own rental "cost" and ratio to gross income is in our opinion all too common and yet most unfortunate.

Examining rooms and clinical space—In all but a few special types of practice (psychiatry, neurosurgery, and some internal medicine practices, for example), there should be a *minimum* of three examining rooms for each doctor who may have office hours at the same time. This may cause even a sole practitioner to consider space for four to six rooms for himself and a possible partner, the addition of whom he considers possible even if not yet determined.

In deciding on the number of rooms, a doctor should consider his use of aides, both at present and as his practice grows and his own time shrinks. One or two rooms may be devoted to his assistants' performing tasks such as: taking initial histories; giving injections; giving EKGs; checking or changing dressings; checking, applying or changing costs; performing parts of well-baby check-ups; and giving routine instructions.

Furthermore, various types of "physicians' assistants" are developing into important adjuncts to physicians themselves. Lack of examining room facilities would be an unfortunate reason to reject such help if and when it can fit one's practice.

Examining rooms may vary in size from as little as 6 by 6 feet to 12 by 12 or more. A standard size is probably 8 by 10 feet in most practices, but any doctor should critically evaluate his own needs. This can be done by measuring a room in which he presently examines patients and considers how well it has served his and the patients' needs. Any equipment, patient dressing facilities, seating for fam-

ily members and other special circumstances should, of course, be included to assure that the resulting size is adequate.

Especially if there will be more than three examining rooms, a so-called "nurses' station" becomes increasingly useful. It is a small area central to the rooms (or to one set of the rooms) at which the nurse or doctor can review charts in advance, make chart entries after an examination, give instructions, make or answer telephone calls, etc.

Laboratory space also must be provided for, both as initially needed and as the practice might change. The space should be convenient to the examining rooms and have adequate closets and shelves to hold lab and other medical supplies. Space for an aide to perform the lab work without undue disturbance would, of course, seem a self evident requirement.

The one item that seems too often ignored is an adequate storage room. The all too often unfortunate result is the piling of supply boxes in examining rooms, hallways and even in the lavatories. A 6 by 6 closet with adequate shelving might satisfy the minimum requirements.

Consultation rooms—There should be a consultation room (or private office) for each doctor if at all possible. As its name implies, it will be used to consult with patients after they have been examined, but it also serves other purposes. As headquarters for the doctor, it is his refuge for dictation, telephone calls, possible research or other preparation, and for just plain relaxation. A hardworking physician deserves such decent and comfortable office space.

Even though a physician may spend only limited time in his consultation room, it is usually preferable that he not share it with his partner, associate or office sharing participant. The space should be his private area for work and personal materials. In addition, when both doctors' schedules should coincide or when one doctor wants to "clean up his office work" while the other has patient hours, he should be able to do so.

Perhaps the suggestion of a separate and comfortable consultation room for each doctor (present and future) results in marginally efficient use of space. However, in our opinion, it is usually worth the cost.

Reception area—This area will hopefully not become a "waiting room" if patients can be seen essentially on schedule and if enough examining rooms are used to promptly prepare patients in advance of examination. Nevertheless, considerable space is needed.

As a beginning rule of thumb, a reception area should be large enough to accommodate twice the number of patients who might be seen in the busiest hour (including emergencies and "walk-ins"). Even this might be inadequate, but it is a good minimum starting point. Any doctor who recognizes his inability to stay reasonably close to his schedule should increase the number of seats considerably.

Little can be considered more inconsiderate to patients, and one can hardly imagine a worse public relations situation, than to have such inadequate waiting room space that patients are forced to stand. Sights of patients in outer hallways and the like are indeed worth avoiding by initially seeking to provide adequate space.

Business area—For a solo physician with three aides, a minimum amount of space for business purposes would be 200 square feet. This space should open onto the reception room to allow a receptionist to easily communicate with patients both as they enter and leave the examining room. It should also permit at least one other person to work comfortably and fairly free of disturbance while typing dictation, preparing third party insurance forms and the like.

Physicians are constantly shocked at the proliferation of business and clerical functions in their practices. Thus, one precaution in planning is to assume the eventual hiring of one more business aide than presently anticipated, and provide for enough business space to at least accommodate that person. The addition of another physician will, of course, ultimately double the typing, third party insurance, telephone and appointment functions enough to require still more help and business office space.

If at all possible, an office layout should provide extra space for at least one business aide to be in a separate room. This aide should normally be responsible for the practice's bookkeeping and patient credit and collection work, all of which should be handled as privately as possible and without interruption. An additional 8 by 10 feet room should suffice for one such aide, while more room will obviously be required for larger practices.

The business space will often have to house all the patient charts and records. These materials tend to grow far faster than anyone ever anticipates, requiring considerable open wall space for shelves to hold them. Perhaps 75 to 100 square feet of such shelf space would be adequate for a busy solo physician if, but only if, his staff routinely culls out all those charts inactive for two years. Such culling requires, in turn, storage space elsewhere in the office (or in the basement if convenient) for the removed, inactive files.

Parking space—While not included directly in a practice's number of square feet, adequate off street and private parking for patients and staff is essential to a good office. A general rule of thumb might be that there be enough such parking spaces for the busiest hour's patients (including emergencies and "walk-ins") plus all full time and part time staff and physicians. This should be the minimum acceptable figure.

In considering the number of parking spaces available, one must be extremely careful to evaluate the needs of all other tenants in the same building. This includes actually seeing the lot at the building's busiest times and counting spaces to determine the number available for each tenant. If the building is not fully occupied, these calculations should be applied to an assumed full building.

The doctor should also critically determine whether the present building might be expanded without a corresponding increase to the parking area. The worst possibility would, of course, be an expansion onto the *existing* parking area with no additional parking space provided. While zoning rules offer some protection in these regards, many physicians have found that once desirable offices change due to decreased parking convenience. □

Cancer coordination in Pennsylvania

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WILLIAM B. KENNEDY, M.D.

HUGH R. GILMORE, JR., M.D.

ROLAND A. LOEB, M.D.

THOMAS MAHAFFEY

'We feel that now more than ever before there is a need for coordination of activities related to cancer since we have a commitment through the National Cancer Act of 1971 to carry this fight to the finish, hopefully In Our Lifetime.'

The authors compose the Executive Committee of the Pennsylvania Cancer Coordinating Committee which is sponsored by the Society and numerous other health related organizations in the state.

Are you aware that "Between 1970 and 1973 mortality rates for cancer of the respiratory system increased 8.5 percent in males and 25.2 percent in females? Cancer of the pancreas increased 24 percent between 1960 and 1970 but showed no change between 1970 and 1973. Cancer of the cervix decreased 10.3 percent between 1970 and 1973 and cancer of the uterine corpus increased 22.2 percent."[1]

Do you know that the two divisions of the American Cancer Society and the Cancer Control Section of the Department of Health have distributed more lifesaving information for the lay public during 1973-74 than ever before in the history of these organizations? A notable breakthrough occured in Pennsylvania in 1974 with the appearance on television of the new film, "Breast Cancer—Where We Are." This film introduced into the medium of television a display of the lifesaving technique of breast self examination which heretofore had been taught only on a one to one basis. A review of the effectiveness of this program indicated that nine out of ten women reacted positively to the program, but that 29 percent of the viewers had never heard of breast self examination and only about one in six of the other 71 percent were actually practicing it. Isn't it a shame that many people are not aware of this method to detect breast cancer early, and even more important, that so very few of those women who are aware of it actually practice breast self examination?

Are our professionals in Pennsylvania informed about cancer? During 1974 there was a definite increase in the number of educational seminars offered for doctors, dentists, nurses, and paramedical personnel along with a substantial increase in programs at the student levels. Since the "turnover" of new medical information reaches 10 - 20 percent each year, the medical profession will soon be far out of date if there are not more continuing education programs. Methods must be found to distribute new information to the busy practitioner who cannot leave his patients to participate in such things as prepared programs in our larger medical centers. Audiovisual material, telephone setups, visiting faculty programs and two-way communication facilities are being developed to keep our professionals up to date in the cancer field.

Is early diagnosis, detection, and rehabilitation available and stressed in Pennsylvania? Uterine cytology programs are available to every

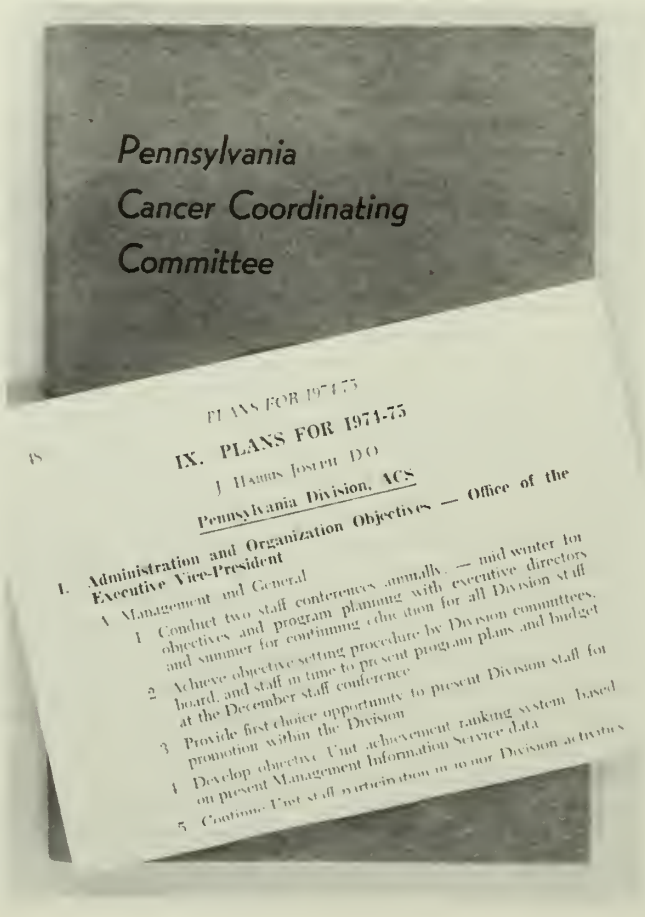
woman in Pennsylvania, as sponsored by the Cancer Societies, State Health Department and various agencies throughout the state. Breast examinations have been done in association with some of these cytology programs and a special program has been started in Philadelphia and Pittsburgh as part of a nationwide breast cancer detection and screening project. If anyone cannot find a program suitable to his or her needs, medical information and services may be located by contacting the Cancer Society. Rehabilitation is available to the cancer patient through both our State Bureau of Vocational Rehabilitation and our Cancer Societies. "Reach to Recovery" programs (for patients who have had breast cancer) and laryngectomy and ostomy clubs have been started throughout the state to help the cancer patient return to an active and productive life.

Are Pennsylvanians doing research similar to that being done in other centers throughout the country, such as Sloan-Kettering in New York, Roswell Park in Buffalo and the M.D. Anderson Hospital in Houston, Texas? In 1973 there were 201 grants funded for research activity in Pennsylvania. In 1974 this number was 253 and the amount of money involved had increased from $13.5 million to over $21 million. Each of Pennsylvania's seven medical schools administer large cancer research programs and this is a significant contribution to research in the field of cancer performed by the scientists in our state.

Have the people of Pennsylvania supported the Cancer Program? Contributions from the public through the annual crusade of the American Cancer Society has been gratifying, as has volunteer participation of the members. While support from our state government has increased slightly during the past several years, the proposed budget for 1974-75 is little larger than that of 1968-69. This indicates a need for re-evaluation of this important area of health care for the people of Pennsylvania.

Are there any plans for the future? Sixteen pages of the recently published Annual Report of the Pennsylvania Cancer Coordinating Committee for 1974 (Figure 1) outline proposed activities for 1975. Every one of you is invited to request a copy of this brochure from the Cancer Control Section of the Department of Health to find out in more detail what is going on and how you can get involved in the fight against cancer.

Figure 1



This kind of report has been published annually since the inception of the Coordinating Committee in 1947. We in Pennsylvania note with pride that we have one of the oldest and most productive committees of this kind in the nation; we would like to improve upon our past record with our future activities.

We expect in the next few years to expand our representation and keep pace with the increased activity stimulated by federal funds for cancer programs. We look for increased state support to fulfill the legacy of each Pennsylvanian to have good cancer facilities within reach for early diagnosis, treatment and rehabilitation to help conquer this disease. We will continue to increase the efforts of the volunteer societies in their programs of public and professional education and service to the cancer patient and solicit their help and expertise to implement both Federal and State funded government programs.

We feel that now more than ever before there is a need for coordination of activities related to cancer since we have a committment through the National Cancer Act of 1971 to carry this fight to the finish, hopefully "In Our Lifetime." By working together and pooling resources the many agencies in the state that are active in cancer work can avoid duplication of effort and waste of precious time and money of researchers, volunteers, and cancer staffs. The members of the Pennsylvania Cancer Coordinating Committee, representing all agencies in the Commonwealth which have an interest in cancer and the cancer patient, will strive to coordinate all cancer activities throughout the state and thus speed progress toward the ultimate control of cancer in Pennsylvania.

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1. Annual Report, Pennsylvania Cancer Coordinating Committee, 1974.

trauma

Emergency room care of stab wound of the abdomen

ELLIOTT M. BADDER, M.D.
Hershey

Abdominal stab wound victims, along with other victims of accidents and criminal assault, have become commonplace. Physicians caring for these patients must use a rational scheme of management. The question of how quickly an operation may be needed should guide emergency room personnel—is an operation part of primary resuscitation?

When the patient first presents to the emergency room, a rapid overall evaluation is performed. Resuscitation is carried out simultaneously. Adequate ventilation must be assured. A pneumothorax may require chest tubes. Tracheal intubation or tracheostomy may be needed for the comatose patient, especially with associated head and neck trauma.

This paper was prepared by the department of surgery of The Milton S. Hershey Medical Center, The Pennsylvania State University, Hershey. The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services assist in the dissemination of information on trauma.

The management of hypovolemia follows. Large bore catheters should be inserted in the upper extremities in the case of abdominal trauma. Especially if the patient is in shock, the inferior vena cava may be injured and fluids infused in the leg may not reach the heart. Blood should simultaneously be drawn for type and cross, hematocrit, amylase, blood sugar, and blood urea nitrogen. If the patient has evidence of hypovolemia as manifested by tachycardia, decreased blood pressure or decline in blood pressure in the upright position, peripheral pallor with cool, clammy extremities, and agitation or obtundation, then intravenous fluids are rapidly administered; 2000 cc of Ringer's lactate are well tolerated.

The rest of the diagnostic evaluation can continue. Mental status is noted. Frequently ethanolism and drug intoxication complicate therapy. The patient may be aggressively combative from his inebriation.

The patient is next undressed to detect all wounds of entry and exit. A nasogastric tube should be inserted to examine gastric contents for signs of blood. If the patient is able to void spontaneously, a urine hematest is performed. If he is unable to void, a Foley catheter should be inserted. If there is any suggestion of shock, the Foley catheter should be inserted as means of following urine output and response to fluid hydration. The rectum should also be examined for evidence of blood.

During the course of early resuscitative measures, if shock is present, a central venous line is helpful. The subclavian or supraclavicular approaches should only be used if the emergency room physician is skilled at the technique. A peripherally placed central venous line would be equally adequate to record central venous pressures.

During these initial steps, constant re-evaluation is carried out. Is resuscitation successful, or must the continuing signs of shock be treated more aggressively? Is an operation required now?

If the stab wound is high in the abdomen up to the 4th rib interspace,

the chance of cardiac penetration is present. Cardiac tamponade should always be suspected when clues such as poor distant heart sounds, tachycardia associated with low narrow blood pressure, and marked venous distention are noted. Central venous pressure helps confirm the diagnosis as it is elevated in the prescence of tachycardia and hypotension. Pericardiocentesis is lifesaving at this time and may be sufficient therapy. Definitive cardiac repair may be necessary if cardiac tamponade redevelops following pericardiocentesis.

The patient with persistent shock not responding to crystalloid infusion should be transferred immediately to the operating room. It is axiomatic that shock will not resolve until the source of hemorrhage is ligated or otherwise surgically controlled. One should not wait for x-rays or the return of laboratory tests. Instead, it is clear the problem must be managed in the operating room as quickly as possible. If properly crossmatched blood is not available, low titer 0 negative blood is given until properly crossmatched blood arrives. It is probably reasonable to start intravenous antibiotics enroute to the operating room.

Usually the hypovolemia will respond to rapid fluid administration. These patients may be studied in somewhat more detail. However, the presence of shock without external blood loss is an indication for operative exploration no matter what the other diagnostic tests show. Chest x-ray, upright PA and lateral, with 3 position abdominal films (upright, supine, and left lateral decubitus) can be done. If there is hematuria, an infusion intravenous pyelogram should be performed, starting the IVP dye before obtaining the abdominal films.

Two cautionary notes here. The patient should be monitored carefully while in x-ray as he may again become hypotensive with continued blood loss. Urine output may be raised artifactually by the contrast medium acting as an osmotic diuretic.

When a complete history is possible, inquire about drug sensitivities, previous operations, medications, and drug addiction. A rapid past medical history is obtained with special concern about cardiorespiratory and renal status.

More judgment is required to evaluate the patient who presents with an abdominal stab wound and no evidence of blood loss. His anxiety may cause tachycardia. What steps are taken to evaluate this patient when the nasogastric secretions and urine are clear, when the hematocrit and amylase are normal? If all such patients are explored, many will have negative findings on laparotomy. Furthermore, about 10 percent will have some postoperative complication, and all will have a prolonged hospital stay.

What findings point toward operative exploration of the stab wound victim? If there is evisceration of an intra-abdominal organ, exploration and wound closure are straightforward. Other patients with stab wounds of the abdomen can be carefully followed monitoring vital signs and examining the abdomen for evidence of peritoneal inflammation. Is the abdomen tender and becoming increasingly so? Are the muscles rigid? Is rebound tenderness present? Is the patient distended? Are bowel sounds changing from normal to hypoactive or nonaudible? Such signs may occur over several hours. The hematocrit and white count can be followed. The presence of an abdominal bruit may reflect an AV fistula or abnormal blood flow. An enlarging hematoma mass may appear. Angiography in these situations may define the problem prior to surgery. Angiography is also indicated when the IVP fails to show a functioning kidney on one side.

What other steps might be taken? If one suspects that no peritoneal penetration has taken place, local exploration of the wound tract with sterile technique may be helpful. Peritoneal lavage for evidence of blood or bowel intraluminal contents in the peritoneum when positive is diagnostic. When negative, one is guided by abdominal findings.

When surgeons at the Charity Hospital in New Orleans changed from the tradition of exploring all abdominal stab wounds in favor of this individualized evaluation, the number of operative explorations diminished by fifty percent. Patients had fewer complications and hospitalization time was shortened. They reported no mortality secondary to delayed exploration and very few patients needing exploration had a delay of their procedure secondary to this period of observation. An adequate period of observation (48 hours) should ensure recognizing all dangerous lesions. Some unnecessary operations may be avoided and the proper urgency applied to those patients requiring it.

Indications for Operative Exploration of Abdominal Stab Wound

Refractory hypovolemic shock	→	Immediate exploration
Responsive hypovolemic shock	→	Hydrate Evaluate with x-rays Type specific blood Foley catheter, NG tube Planned laparotomy
Evisceration	→	Hydrate, blood tests, typed blood Planned laparotomy
No evidence of decreased blood volume	→	Observation with: Laboratory studies Chest and abdominal x-rays NG tube, urine Repeated hematocrit, WBC, pulse, blood pressure measurements ↓ remains stable → home in 48 hours abdominal examination ↓ any change in findings → OR (peritoneal signs, cessation of bowel sounds)

Managing the cardiac arrest emergency

ROBERT L. KRAUSE, M.D.
Philadelphia

Cardiopulmonary resuscitation—order from chaos at the site of arrest by a modified team approach for hospitals

Since the early 1960s methods for the effective emergency treatment of cardiac arrest have been refined and standardized to such an extent that thousands of individuals in the health care industry receive training and retraining in the minute details of proper mouth to mouth respiration and external cardiac compression. Generally accepted methods of definitive therapy for cardiac arrest victims are detailed in literature and audiovisual materials, which are readily available from such sources as the American Heart Association. The effective use of intravenous or intracardiac drugs, defibrillation, and pacemakers is spelled out in great detail in these materials and is included in the training of most medical students and house officers.

Dr. Krause is clinical associate professor of medicine, cardiology division, at The Medical College of Pennsylvania, Philadelphia. This paper is a result of work done during the author's tenure as assistant professor of medicine in the department of medicine at Temple University Health Sciences Center.

Hence, the standardized emergency and definitive therapy that the salvable patient must receive to survive is often well known to the individuals who arrive at a cardiac arrest site. However, the efficient delivery of this vital therapy is often thwarted by the chaos and disorganization almost invariably present at such a site. Failure to apply the same care to detail in the organization of the team around the victim as has been applied to the protocol for timing of various drugs may result in failure of the entire effort.

Because of the obvious need to immediately establish at the site of a cardiac arrest a team of individuals, who need not be preassigned but whose roles are fixed and clearly spelled out, the author in 1971 originated and implemented the following modified team approach to the cardiopulmonary resuscitation (CPR) procedure at Temple University Hospital in Philadelphia. (Figure 1)

At the site of each cardiac arrest, a 6-member team shall immediately be established. Designations are as follows: 1. ECG; 2. Ventilate; 3. Pump; 4. IV; 5. Float; 6. Drugs.

The most senior member present from the department of medicine or cardiology will immediately assume absolute command of the operation and the role of ECG. He will immediately assign a specific role to 5 other individuals, each of whom will assume sole responsibility for carrying out that role and that role only, under the direct command of ECG.

The specific role of each of the 6 team members is as follows:

1. ECG

a. Direct entire operation from the location of the electrocardiograph machine.

b. Keep area clear.

c. Make all therapeutic decisions.

d. Compile data sheet at the termination of cardiac arrest procedure.

2. Ventilate

a. (Preferably an anesthesiologist). Assume sole responsibility for ensuring adequate ventilation.

b. Monitor pupils periodically.

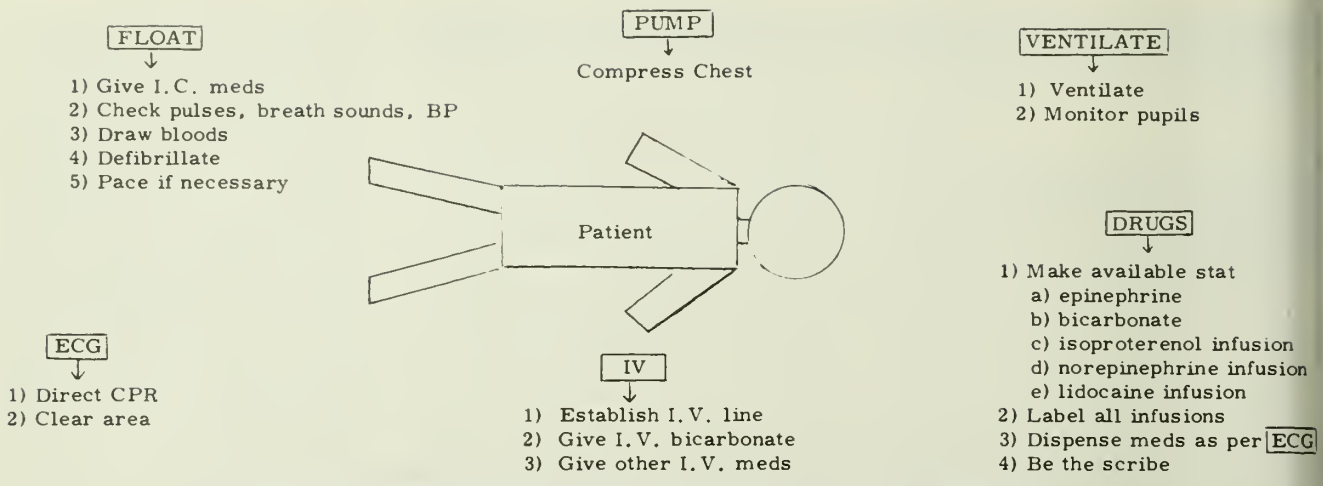

Figure 1: Organization of the team at arrest site showing responsibilities of each position. I.C. = intracardiac; I.V. = intravenous.

3. Pump

a. Assume full responsibility for performing correct external cardiac massage.

4. IV

a. Assume full responsibility for providing an intravenous line, by cutdown if necessary.

b. Give all intravenous medications.

c. Give bicarbonate every 5 to 10 minutes.

5. Float

a. Assume full responsibility for delivering all cardiac interventions except cardiac compression (intracardiac drugs, defibrillation, transthoracic pacemaker).

b. Check pupils, adequacy of ventilation, and blood pressure at intervals.

c. Draw bloods as required (especially arterial blood gases).

6. Drugs

a. Make immediately available intracardiac epinephrine with appropriate needle.

b. Make available intravenous bicarbonate immediately and at intervals of 5 to 10 minutes.

c. Make immediately available an intravenous infusion of 2 mg isoproterenol in 500 cc 5 percent Dextrose in water with filled intravenous infusion set with microdrip, ready to piggyback into vein.

d. Make immediately available an intravenous infusion of 3 ampules of norepinephrine in 500 cc 5 percent Dextrose in water with filled intravenous set and microdrip, ready to piggyback into vein.

e. Make immediately available 1.0 gm lidocaine in 500 cc 5 percent Dextrose in water with filled intravenous infusion set and microdrip, ready to piggyback into vein.

f. Make immediately available syringes containing 100 mg lidocaine, and 10 cc of 10 percent calcium chloride solution.

g. Label all infusion bottles with large labels.

h. Dispense medication only at the direction of ECG except for routine bicarbonate.

i. Keep record of drugs given, time given, and time into CPR procedure. Relay this information to ECG at regular intervals.

The above organizational framework was distributed throughout the hospital as part of a memorandum detailing the hospital's cardiac arrest system. It was included in the training of CPR to all new and old house officers and to medical students and nurses, and was detailed in a publication directed to pharmacists.[1]

Since the introduction of this team approach, it has been clearly observed by all persons involved in the CPR procedures in the hospital that the delivery of definitive therapy to the victims has been streamlined and that the chaotic atmosphere attendant upon frequent shifts of positions and roles by too many participants and too many directors has been minimized or eliminated.

It is the distinct impression by those responsible for tabulation of mortality statistics of cardiac arrest procedures that survival has improved compared with statistics from years prior to implementation of the team approach. However, definite documentation of such efficacy would require and must await a prospective study comparing alternative methods.

Advantages of this team approach include the following:

1. It does not require specific individuals. The specific roles can be filled by any competent persons available who have been previously taught the responsibilities of each role.

2. It provides for a single captain, which is as necessary in the running of a CPR procedure as in the commanding of a ship at sea.

3. It requires that each role or limited set of functions be the ongoing responsibility of a single individual, thus maximizing the chance that those functions will be completed without interruptions or distractions.

There are no obvious disadvantages to this team approach, which has already been adopted by other hospitals in the Philadelphia area.

It is hoped that more widespread implementation of such an organized and detailed delivery system for definitive therapy at the site of cardiac arrest will result in significant improvement in survival. □

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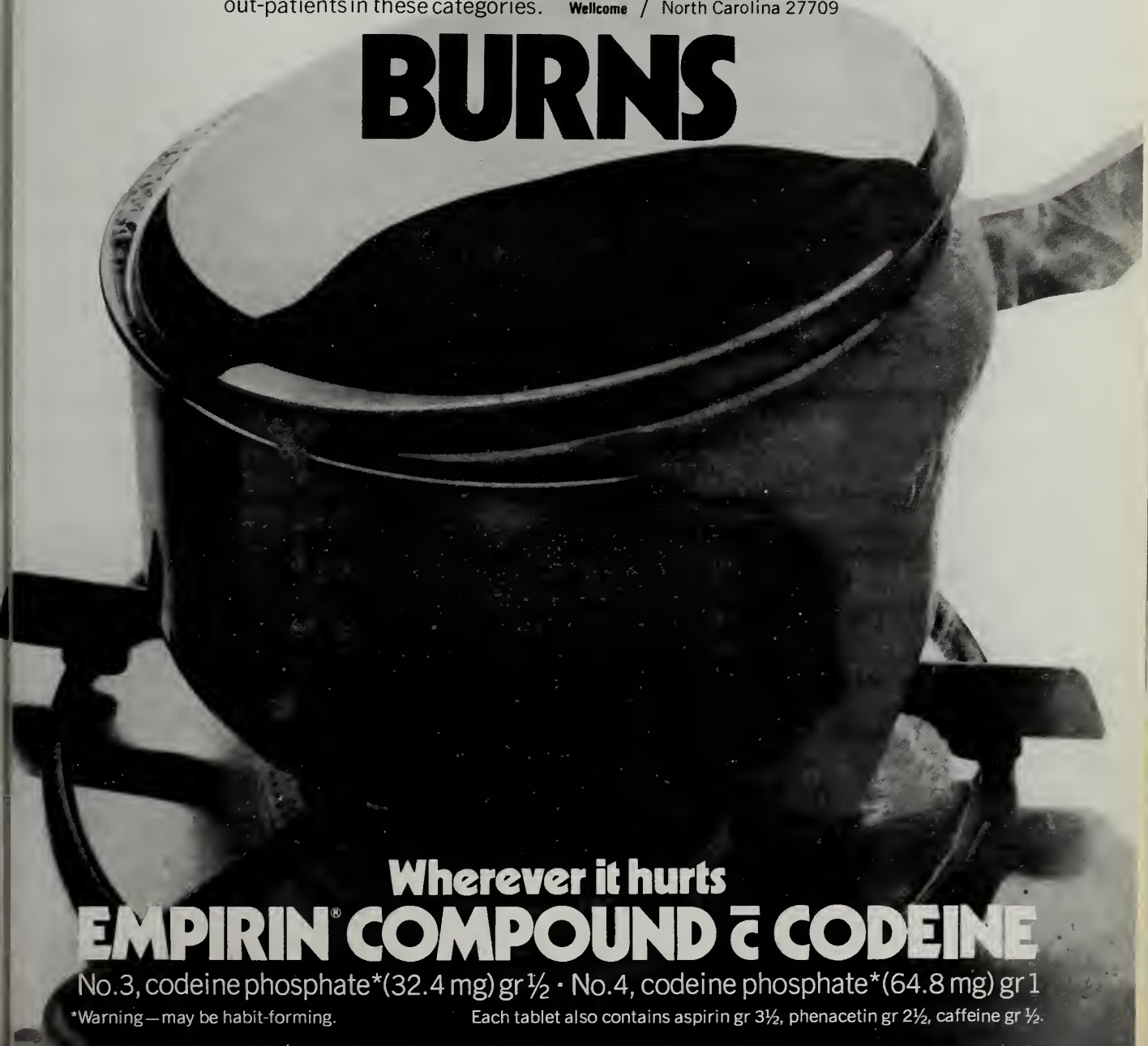

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ON THE FRONTIERS OF DIABETIC RESEARCH...

What is Diabetes?

Although a medical scribe of ancient Egypt first made reference to diabetes mellitus in man, today, nearly 4000 years later, only meager specific knowledge exists as to the basic cause of the disease. Without such knowledge it has been possible to provide for limited control only *after* diabetes manifests itself in the form of elevated blood glucose. The possibility of prevention or even cure of diabetes, however, must depend on a full understanding of the genetic defect and/or defects underlying the disease. Our current understanding of diabetes may be compared to our former understanding of another disease of metabolic abnormality, phenylketonuria; only when the genetic lesion of that disease was discovered did it become possible to institute current programs of treatment.

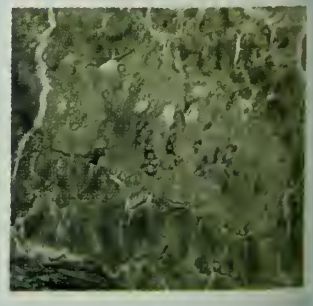
Basic Diabetes Research at Upjohn

For more than ten years the Diabetes and Atherosclerosis Research Group at The Upjohn Company (W. E. Dulin, Director; G. C. Gerritsen; M. G. Soret; A. Y. Chang) has addressed itself, in a series of unique experiments, to the very basic question: What is diabetes? As with all such fundamental research, practical results are slow in coming and the work of the Group has at times raised more questions than it has been able to answer. It appears now, however, that the research is moving toward important conclusions which may, over the next several years, have significant bearing on our understanding of diabetes and, hopefully, on our ability to control it.

The Chinese Hamsters

In the middle fifties, a group studying cytogenetics in Chinese hamsters at the Children's Hospital Medical Center, Boston, Massachusetts, discovered that certain hamsters develop diabetes spontaneously. The Upjohn Research Group obtained some of these hamsters in 1962, and by controlled inbreeding, succeeded over the years in producing large numbers of diabetic animals for study. To assure continuity of the research in the event of a catastrophe, duplicate breeding stock of all the inbred families are maintained at another site. These are the only such colonies in the United States today. In the course of the research, Upjohn has cooperated with scientists in academic

Normal Chinese hamster, pancreatic tissue. Note blue-stained insulin granules which appear within the beta cells of the islet of Langerhans.



Diabetic Chinese hamster, pancreatic tissue. Insulin granules are almost totally absent. Though beta cells are present, there is some degranulization and vacuolization. The diabetic process is similar to that observed in human pancreatic tissue.

centers, both in America and abroad, in various specialized studies. When possible, these scientists have come to work for a time in Upjohn laboratories. In other cases, specially selected hamsters were transported to outside research facilities.

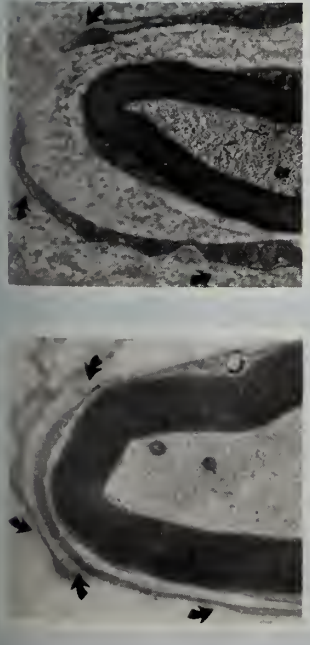
Closer to Man

While other species besides man develop diabetes spontaneously, the Chinese hamster appears to be the best laboratory animal model to study, since its disease is remarkably similar to diabetes in man. Chinese hamster diabetes, like human diabetes, is a complex disease. Like humans, the hamsters have more than one variety of diabetes, including the juvenile, insulin-dependent type as well as the maturity-onset type. They also develop pathological lesions in the retina, kidney, and peripheral nerves, as do human diabetics.

Diabetes is as complicated genetically in hamsters as it is in man. The type and severity of the disease appears to vary with the number of genes involved. Fortunately, genetic analysis can progress faster in the hamster since two or three generations can be produced per year.

Hamsters with Diabetic Genes Overeat

Perhaps one of the most significant observations is that hamsters with diabetic genes have significantly increased food consumption prior to development of clinical signs of diabetes. Further, if the animal with diabetic genes were limited to a normal amount of food, onset of diabetes could be delayed and reduced in severity, and the animal could have a normal life span of 34-35 months. Those animals that develop the clinical symptoms have a shorter life span, which varies with the severity of the disease. Interestingly, decreases in the incidence of human diabetes were noted during the siege of Paris in 1870, and during and immediately after World War II in Europe. It has been postulated that decreased food intake during these periods may have delayed the onset of the disease or reduced its severity to a point where hyperglycemia did not appear.



Peripheral diabetic neuropathy. Top photo, Chinese hamster; bottom photo, 58-year-old diabetic man. The encirclement of myelinated nerve fibers by thin Schwann cell processes, indicated by arrows, is a cellular reaction to chronic demyelination, and is a characteristic finding in this condition in both man and the Chinese hamster.

74J-3795-6 B

Implications for the Future

The purpose of the Upjohn Research Group is to attempt, through its work with the Chinese hamsters, to find the basic genetic lesion or lesions associated with diabetes. Such knowledge could provide the information necessary to predict the disease in humans, to define its exact mode of inheritance, and to initiate studies aimed at correcting the defect or defects. Hopefully, it will eventually be possible to devise methods to prevent the development of the abnormalities associated with the disease, if the defect or defects can be corrected. Such methods may replace all treatment in use today.

Already, a beginning has been made in the establishment of programs to apply the information gained from the hamster research. The Upjohn Group is currently working with pediatric endocrinologists in an attempt to define the genetics of human diabetes and to confirm retrospectively whether the discoveries concerning dietary manipulation in genetically diabetic hamsters can be applied to humans. Should the results of these investigations be positive, and if it becomes possible through further work with the hamsters to identify prediabetic humans before they develop signs of the disease, an enormous stride will have been made. Even though the investment in this research is made with no guarantee, this risk must be undertaken.

Note: For bibliography of published papers, please write to W. E. Dulin, PhD, Upjohn Diabetes and Atherosclerosis Research Group, 7241-25-9, Kalamazoo, Michigan 49001.

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continuing education

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Appendicitis in pregnancy

JOHN H. BLEWETT, JR., M.D.
PAUL A. WENGERT, JR., M.D.

Harrisburg

An 18 year old white female, 6 months pregnant, was admitted to the Polyclinic Hospital with a history of pressure in the upper abdomen and vomiting. The patient had received the usual anti-emetic medications prior to admission but continued to vomit. Because of her intractable vomiting she was admitted to the hospital.

A physical examination revealed an abdomen distended by a 6 month pregnant uterus. There was mild pain with diffuse tenderness in the abdomen. The lungs were clear and the heart was normal. Temperature was 100.4 degrees, white blood count 17,800 with 80 neutrophils and 2 stabs. Admission diagnosis of dietary indiscretion with possible psychogenic vomiting and electrolyte imbalance was made.

Over the next 5 days the patient's temperature returned to normal, her vomiting stopped, and her white blood count decreased to 14,200, but with a marked shift to the left with 88 neutrophils and 3 stabs. Furthermore, the patient's belly became more and more distended and pain was localized in the right flank. In view of the persistent right flank pain the diagnosis of acute appendicitis was entertained and a surgical consultation was obtained. An exploratory laparotomy was performed and a perforated retrocecal appendix was removed.

The authors are in the department of surgery at Polyclinic Hospital, Harrisburg.

The wound was drained and packed and antibiotic therapy was instituted. Hydroxprogesterone and Vasodilan were given to prevent onset of early labor.

The patient did remarkably well and was discharged on the 14th postoperative day after a long period of ileus. Three months later she gave birth to a healthy baby.

Appendicitis, although a common disease in the young, is infrequent in the pregnant female. Brant[1] in a review of 42,936 deliveries noted a 0.06 percent incidence of acute appendicitis during pregnancy equally distributed throughout the gestation period. Other investigators have noted a similar percentage. Complications in these women were significant and a 16.7 percent fetal mortality rate was noted. Thus, it is of paramount importance that the diagnosis be made early.

Appendicitis is the same disease process in the pregnant as the nonpregnant, but pregnancy may obscure the diagnosis. Nausea, vomiting, dysuria, and frequency are all common in pregnancy, and these symptoms may be interpreted as features of pregnancy. However, pain is the one important constant symptom of appendicitis, and the physician should be alerted to the possibility of acute appendicitis when persistent pain accompanies the above symptoms. In addition a white blood count may be helpful, as it is usually elevated with a shift to the left.

Furthermore, one should be aware of the fact that the enlarging uterus displaces the appendix upward and outward as gestation continues. Thus, pain may be located in the right upper quadrant or flank as in the case presented rather than the classical right lower quadrant position.

There is no place for conservative treatment of appendicitis and once the diagnosis is made, it is of the utmost importance to operate. Fetal mortality increases with perforation and Hoffman and Suzuki[4] report a 35 percent fetal mortality in those instances.

Thus, early diagnosis leading to early operation can decrease fetal and maternal loss dramatically.

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The realities of law and medicine:

Physician extender and therapy by prescription

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The system by which Americans receive health care is in a state of rapid change. Many areas of concern have been identified. They may be broadly categorized into four groups: financing,[1-5] organization,[1,3,6,8] administration,[9,10] and access.[11-13] While all of these may be considered major issues, shortcomings involving equality of access and availability of primary care have received great emphasis and are the *raison d'etre* for physician extenders.

In order to meet the health care needs of society a number of changes must be wrought within the health care system. New responsibilities are being placed on health practitioners and new categories of practitioners are being created.[14,26] While the exact responsibilities of these practitioners are still evolving in many areas, as could be expected, some have suggested that the new practitioners should have authority to prescribe federal legend medications.[27] Indeed, one major study to assess the clinical judgment of nurse practitioners used an evaluation of drug therapy as a quantifiable measurement of performance.[28]

To begin a consideration of the legal basis for and framework of prescribing of drugs, it is important to consider the two federal statutes which regulate drugs, the Federal Food, Drug and Cosmetic Act[29] and the Controlled Substances Act.[30] While both of these statutes have a significant impact on the use of drugs, neither determines who may or may not engage in prescribing drugs.[31,32] Both statutes focus on drugs and their use and control, not on the qualifications of the individuals who may prescribe them. Under the legal concept known as "police power," the authority to make any constitutional law for the protection of public health, safety or welfare, the determination as to who may prescribe is reserved to the states. Hence, it is the state governments which have the responsibility of determining who may legally prescribe drugs which a federal agency, the Food and Drug Administration, deems to meet the standards established for prescription-only status. Conceptually, it is important to realize that the federal statutes are drug-oriented, not practitioner-oriented.

Since it is clear the federal regulatory scheme has nothing to say about the qualifications necessary to engage in prescribing, consideration must shift to the state and the various statutes and regulations at that level. Much has been written about various approaches to regulating the activities of physician extenders[14,33,54] yet most authors focus on the general issue of whether the legal basis for the actions of physician extenders should be statutory or not, and if so, how narrowly should their actions be limited. Few have focused on specific activities suggested for physicians' assistants, nurse practitioners or others in order to evaluate the legal feasibility of their performance.

To begin an analysis of the legal feasibility of prescribing by physician extenders, we must differentiate between dependent and independent functions of the extender. Dependent functions are those which the extender seeks to perform under color of delegation.[14] Basically the reasoning runs like this: the physician is authorized to engage in the activity in question and if he delegates that authority to a qualified extender (the assumption of qualification critical), the extender may then legally perform the task. With regard to dependent prescribing by the extender, three situations must be considered.

The first occurs when the physician has ordered prescription medication for a patient and attempts to anticipate any changes or complications by authorizing the extender to provide for the patient certain specified alternative drugs depending upon observation of the patient's condition and other factors within the expertise of the extender. In such a situation the "prescribing" by the extender would probably be acceptable, for the extender is performing a delegated function of the physician based on a bonafide physician-patient relationship which was established *a priori* by the physician.[47] In effect, the extender is performing a dependent function of limited scope because the alternatives have been selected by the physician.

The second situation occurs when the extender operates under a system of standing orders or a protocol.[28] While quite similar to the previous circumstance, it varies slightly in the degree of structure. A protocol is more formal, but the initial physician-patient relationship renders the duties delegable. The alternatives are likewise limited here. Should the extender attempt to work with a patient and prescribe

This paper was presented at the Third Annual Conference on New Health Practitioners, "Accepting the Challenge: A Decade of Experience," sponsored by the American Academy of Physicians' Assistants and the Association of Physician Assistant Programs in April. Dr. Fink is assistant professor of pharmacy administration at the Philadelphia College of Pharmacy and Science and a member of the Pennsylvania Bar.

for him without an initial physician contact, his activities would be outside the realm of delegation and hence, legally questionable. The physician should always introduce his patient to the extender and explain the latter's role.[54]

Third, when the extender seeks to authorize renewal of a prescription originally generated by the physician or to originate a new prescription without a direct order from the physician at the time, there is a greater reason to question the legality of such an act. This borders on and perhaps may even be independent functioning because, presumably, the physician has had no input into the therapeutic decision.

Another author has suggested six essential elements which must be present for an extender to feel that he may prescribe under the aegis of authority delegated by the physician, without definite statutory authorization of delegating the authority to prescribe:

1. that a bonafide physician-patient relationship has been previously initiated by the physician from whom the delegation has arisen;
2. that by clear and definite instruction as by written or oral orders (dangerous if such orders represent many drug alternatives), and dependent on observations and findings the physician's assistant is qualified by law and training to make;
3. that the same considerations be given to prescription devices and the administration thereof;
4. that the delegation may not fly in the face of stricter local or federal laws that prohibit same, as in circumstances of transfer of controlled substances or paraphernalia;
5. that the physician have actual authority to prescribe within the state law;
6. that the physician's assistant shall in no way extend the scope of the delegation.[47]

If these guidelines are followed, a legal question is unlikely unless there is a clearly stated statutory ban on prescribing by extenders. Then no standards could render legal status to the action.

Turning now to the circumstance where there is no delegation or derived authority, what is the independent authority of an extender to order prescription drugs? Absent a statute permitting prescribing of medication or an adequate and authorized delegation, the extender has a legal status of a layman and hence no right to possession of prescription drugs, no right of prescription and no right to administer such agents.[45,46]

While a layman does have a "right" to self medicate, it applies only when the drugs self prescribed and administered are not prescription drugs or devices. If the layman's activities run contrary to this exception, the drug would be subject to seizure as misbranded.[55,56] The same would be true should an extender attempt to order a prescription drug without delegated or statutory authority.

Returning to our original point, it must be recalled that authority to prescribe exists only on the basis of state established qualifications.[31] If a state chooses to authorize practitioners other than physicians to prescribe—and many have in the cases of dentists, optometrists, and podiatrists—then the federal law will accept that determination of qualification. Without such a determination as expressed in a statute, one who falsely issues a prescription causes legend drugs to be misbranded—a federal offense.

In order to be on most secure grounds it is suggested that an extender should not attempt independent prescribing absent an enabling statute which explicitly permits delegation of the authority to prescribe. Whether contained in a general delegation statute[33,34] or in a statute which narrowly construes the domain of a particular type of extender,[27] a provision directly addressing the capability to prescribe, either positively or negatively, should be present.

It is important that the prescribing function be addressed in a statute rather than a regulation promulgated by the state medical board. Absent statutory authorization, a regulation permitting independent prescribing by an extender would in all likelihood run contrary to the state medical practice act and be invalid on its face.

An example of the problem that would exist when an extender attempts to prescribe without legal authority is the situation in Wyoming.[52] The secretary of the Wyoming Board of Pharmacy has stated that extenders "have claimed that they have permission to write prescriptions from the medical board, from the doctor, or even from myself. However, in Wyoming the law states that the physician's assistant may not prescribe, although he may act as the doctor's agent." The secretary has suggested that the pharmacist who receives one of the invalid prescriptions either refuse to dispense the medication or contact the physician for verification. If the latter approach were followed this would result in the prescription order originating with the physician, not the extender. The medication order should then be reduced to writing and placed on file, while the original, invalid order is discarded.

The Wyoming Board of Pharmacy reportedly was checking pharmacies' records to detect such violations of the law. The secretary of the board considered such action "necessary even though one county in Wyoming has a ratio of 2,700 patients to every doctor and could use more medical help from assistants."[52] In light of such positions by boards of pharmacy, the extender may encouter some resistance from local pharmacists in the attempt to begin prescribing.

Shifting focus to the liability aspects of drug prescribing, the extender who engages in such activity must be concerned with two types of potential legal problems. The first, violation of criminal statutes, could bring rather severe penalties. Unauthorized ordering of prescription medication could result in a charge of violation of the Federal Food, Drug and Cosmetic Act.[57] Such an allegation could be made not only against the extender but against the pharmacist as well. A pharmacist who dispenses a prescription written by an individual not qualified by state law to prescribe would be accountable

both criminally and civilly for dispensing a misbranded article.

Additional criminal liability exposure lies in the area of practicing medicine without a license. Here, too, the pharmacist would share culpability for aiding and abetting the illegal practice of medicine.

In the area of civil liability the extender could be held accountable for his deviation from professionally acceptable standards in the use of drugs.[58-63] Should a civil suit for professional negligence result from the act of prescribing, the plaintiff would probably seek to involve the physician and the pharmacist as well.

Earlier reference was made to the fact that the extender must be qualified to participate in the act of prescribing. Some have suggested that the physician with whom the extender works will be primarily responsible for assuring the quality of performance,[35] while others suggest that licensure is required.[27] Regardless of the approach finally adopted, one point should be stressed—the pharmacist owes the patient an independent duty to protect him from harm, especially from that which results from the improper use of pharmaceuticals.[64]

While there is little doubt remaining concerning whether physician extenders are acceptable to physicians and patients,[65 66] there may still be a way to go with other health practitioners.[67] However, extenders have won over the group with whom they must be primarily concerned—patients—and should be encouraged to continue in the quest to render health services of the highest quality to Americans. □

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Three faces of splenic rupture

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Rupture of the spleen remains one of the most common intra-abdominal injuries secondary to blunt trauma. However, the diagnosis of the splenic rupture may be either very easy or very difficult. Traumatic rupture of the spleen may present in one of three different ways as illustrated in the following case reports.

Case 1—A 31 year old black female was brought to the Polyclinic Hospital emergency room stating that she had been beaten up earlier in the morning. Vital signs taken on admission revealed a pulse of 88/min., respirations 22/min., blood pressure 108/80mm Hg. She was complaining of severe pain in the left lower thoracic and left upper quadrant regions where she stated she had been kicked. Shortly her blood pressure dropped to 60/40mm Hg and as fluid resuscitation was already begun, she was transfused. A chest x-ray was obtained which revealed fractures of the 7th and 8th ribs in the left posterolateral area of her thorax. After two liters of fluid had been given her pressure was restored to 110/70mm Hg.

A complete blood count upon admission revealed a hemoglobin of 9.7 gms percent, a white count of 11,700/mm.^{3} Urinalysis was normal. A peritoneal lavage revealed grossly positive dark red blood coming from the peritoneal cavity. The patient was taken to the operating room where there was noted a laceration through the posterior lateral surface of the spleen extending down into the hilum. Approximately 1000cc of blood lay within the peritoneal cavity. A splenectomy was performed.

Case 2—A 21 year old white male was admitted to the emergency room

This paper was prepared by the department of surgery of Polyclinic Hospital, Harrisburg. Dr. Patterson is chairman of the department.

after an automobile accident with the presenting complaints of left upper quadrant and chest pain with abrasions on the left side of the chest. The pain made him take shallow rapid respirations and was increased with breathing. Breath sounds were equal bilaterally. The patient's left ribs were quite tender to palpation and his abdomen was tense with guarding bilaterally especially in the upper quadrants. No rebound tenderness, masses, or splenomegaly were palpated. Vital signs on admission revealed a pulse of 88/min., and blood pressure 120/70mm Hg. X-rays revealed an undisplaced fracture of the left 8th rib. The patient's vital signs continued stable with a blood pressure of 120/70 and a pulse between 80-90. He was admitted to the hospital for observation. Laboratory studies on admission included a blood count which revealed a hemoglobin 14.2 gms percent and 22,800 white count. Urinalysis was normal. On the floor his vital signs remained stable. However, he continued to complain of left upper quadrant pain. His hemoglobin then dropped from 14 to 12 two hours after admission and a splenic scan was obtained approximately four hours after his admission; it was positive for splenic rupture. A peritoneal lavage revealed a grossly bloody return and the patient was prepared for the operating room approximately six hours after admission. Exploration of the abdomen revealed approximately 1200cc of blood and the spleen was noted to have a stallate laceration, being fractured into a number of pieces. Splenectomy was performed.

Case 3—A 17 year old white male had had a motorcycle accident and sustained injuries to his chin, left arm, and left side. After the accident he saw a local physician who felt his injuries were superficial. Since that day he had had pains across the upper quadrants and epigastrium associated with shortness of breath. The pains were sharply increased on deep breathing and hiccuping. When he presented in the emergency room two days later, vital signs revealed a pulse of 80 and blood pressure 140/98. On examination, his chest was clear to auscultation and percussion; but he did have some tenderness of the anterior and lateral rib cage along the 9th, 10th, and 11th ribs bilaterally. The abdomen revealed tenderness in all quadrants, but mainly in the left upper quadrant with some guarding. No masses or splenomegaly were palpated. Bowel sounds were normo-active. The patient's hemoglobin on admission was 13.9 gms percent and 10,300 white cell count. Although his hemoglobin never actually fell, he still complained of pain in the left upper quadrant, especially with palpation. Spleen scan obtained the morning after admission revealed a scalloped edge on the anterior surface of the spleen which was felt to be inconclusive for the tentative diagnosis of splenic rupture. Chest x-rays and x-rays of his ribs were normal. The second day after admission, a splenic angiogram was obtained which revealed multiple small punctate areas of extravasation of contrast from the small distal inferior splenic arteries. There was also noted to be a small defect superior to the splenic artery which was thought to represent a splenic hematoma. The patient was then taken to the operating room on the second day post admission, and a splenectomy was performed. The spleen was lacerated along the anterior surface, and approximately one pint of blood was noted within the peritoneal cavity.

Discussion—As illustrated by these three cases, there are actually three faces to rupture of the spleen and three times when a diagnosis can be made. One third of all patients present in shock, with characteristic findings. Approximately 50 percent will be diagnosed after repeated examinations, observations, and radiographic procedure. The remaining 13 to 15 percent are usually diagnosed with observation over a period of forty-eight hours or more.[1,2]

In our first case, the diagnosis was obvious at the first examination and a peritoneal lavage was immediately positive. Preparations were made for immediate splenectomy.

In the second case, the diagnosis was not immediately obvious at the time of initial evaluation of the patient. However, on repeated examination with the patient's continued complaints of pain in the left upper quadrant, both the spleen scan and the peritoneal lavage were performed and were positive. Preparation for a splenectomy was then made within eight hours of the patient's admission.

In the third case, the patient was initially thought to have only contusions and to have essentially a negative physical examination until he presented two days after his accident complaining of left upper quadrant pain and was admitted with stable vital signs and normal hemoglobin and hematocrit. In this case the spleen scan was equivocal and it was necessary to proceed to the splenic arteriogram to make the definitive diagnosis. The patient was then operated on the 5th post accident day.

Diagnosis of a ruptured spleen is usually made on a history and physical examination with any injury to the left upper quadrant or lower chest making the examiner suspicious. Injury to the spleen most commonly occurs with blunt trauma which in the younger age group is usually from a fall and in the older is usually from automobile accidents.

Vital signs in most patients are observed very closely; 60 to 70 percent may actually have signs of hypovolemia.[1,2] The white blood count may also be elevated in excess of 10,000 and the hematocrit may be below 40 percent. Diagnosis is further facilitated by frequent observation of the patient and of the patient's serial hemoglobin and hematocrit values. In many instances, it is neccessary to call upon radiologic colleagues for assistance in diagnosis of the ruptured spleen. The most sensitive, least traumatic, and possibly the quickest test is a splenic scan which usually shows a filling defect within the spleen associated with the area of rupture. Occasionally, these are equivocal; a splenic arteriogram to look for the extravasation of dye from splenic arterial branches or the evidence of an avascular filling defect as with a subcapsular hematoma may be needed. Once the diagnosis is made, the treatment is splenectomy. □

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House of Delegates acclaims president's address

(Continued from page 6.)

is perfected, the malpractice insurance rates are soaring out of sight, climbing by 400, 500, and 600 percent a year. Who is it who will pay these costs? In part it will be the taxpayers of this Commonwealth, for these teaching institutions are supported by the Commonwealth. The teaching of medicine, which began in this nation 200 years ago in Pennsylvania, is now mortally threatened.

And what of our community hospitals? These community institutions which are built with contributions from the citizens of the Commonwealth, which provide employment to more than 127,000 Pennsylvanians, which receive the loving and unselfish devotion of thousands of community volunteers every day. These institutions are threatened as well. Here are some examples: Lower Bucks Hospital's malpractice premium of $130,000 going to $980,000; the premium at Muhlenberg Medical Center has doubled; the premium for the Medical Center of Beaver County, up from $60,000 to $300,000; Robert Packer Hospital in Sayre, up from $35,000 to $107,000; Pennsylvania Hospital, up from $200,000 to $900,000.

In the midst of this deteriorating situation, there is one bright spot. In the past sixty days, since the formation of the 805 Committees, you have performed magnificently. This is especially true of the Auxiliary 805. The fruits of your labor can be seen around this room in the clippings. You have spread the word through your local newspapers, radio, and television stations that Pennsylvania is indeed in the midst of a health care crisis. You have generated hundreds of letters to legislators. I truly believe that a majority of our citizens understand that there is a crisis and that it does impact on their health care.

We have also obtained the attention of the Legislature. I believe there exists among many lawmakers a genuine desire to pass meaningful reform legislation. But there are some who are adamantly opposed to any change in the tort law. Those lawmakers, mostly trial lawyers, are showing the public that their opposition to change stems not from principle but from personal interest and the lure of profit from making adversaries out of patients and doctors.

Briefly stated, the task now before us is to agree upon an explicit sequence of actions which will permit each of us to care for our patients on the basis of our knowledge and skill applied with care and compassion unfettered by restrictive legal intrusions and interpretations which act only to the detriment of the patient. Webster defines malpractice as "the treatment of a case by a surgeon or physician in a manner contrary to accepted rules and with injurious results." The problem is that those rules are being written not by persons knowledgeable in the care of the sick but by lawyers and the judicial system. Let me read you a few brief abstracts from the commencement address delivered by the Chancellor of the University of Rochester to the graduating class in Medicine and Dentistry last year:

> . . .before your careers have run their courses, these lawyers may have more influence than you over what you do, how you do it and how you are rewarded...defining the range of treatments allowed in specified circumstances, the criteria by which you are to choose the treatments, the priorities you must assign to different patients, requiring you to keep detailed records to prove that you are in full compliance and punishing you unless you can refute beyond a reasonable doubt *their* assumption that your failures result from not following *their* rules, regulations and requirements. Should you have the temerity to differ with lawyers, you will be backed by the authority of your knowledge, your science, your skill, your art, your experience, your judgment, your dedication and your conscience. Which is to say that in the eyes of the law, you will have precious little backing, for knowledge, science, skill, art, experience, judgment, dedication, and conscience—whatever else, their merits do not constitute due process of law.

I dwell upon this aspect of the problem because it is basic and from it springs the precipitating factors of the present crisis—the cost and the availability of malpractice insurance. Unless we change the root causes through correction of the tort system, the cost of medical care, the cost of insurance and its non-availability can only continue to increase. Our chief concern is our ability to take care of our patients properly.

It is not my intention to again give you a detailed review of events in the malpractice crisis in Pennsylvania. This has been done in my presidential letters and pages and in the background material in your packet. However, in view of the resolutions that have come in and in view of discussions over the state and with many of you, I would like to point out a few things:

I. Argonaut insurance company

In 1969 because a number of physicians (Class V) in this state could not get malpractice insurance, the PMS sought a carrier who would enter the state since no existing carrier was willing to do so. Argonaut was the only one interested. At that time, they had a sound financial position and were strong. A five-year contract, renewable each year, was signed by which they agreed to take on every member of the Society unless rejection was concurred in by our Commission on Professional Liability Insurance. Because of losses and the increasing risk, Argonaut along with every insurance carrier with the exception of Medical Protective, has been trying to get out of the field and all have been refusing to expand.

In January 1975, Argonaut threatened to withdraw from Pennsylvania despite our contract and were compelled to continue only because the PMS went to court and obtained a court stipulation compelling them to continue. Simultaneously, Argonaut filed for a 256% rate increase. After objection by and conference and discussion with the PMS, this was withdrawn and a refiling submitted at 207%. This increase was approved by the Insurance Commis-

sioner. The Society did not file an objection because our actuarial advice, while questioning the rate of increase, could not factually support a specific lesser amount. We also decided to withhold any objection because of the possible adverse effect upon our court action and thereby permitting Argonaut to withdraw from the state.

At this time, I would like to say that we have a malpractice problem because some lawyer and some physician are second-guessing, Monday morning quarterbacking our decisions in patient care. I and your Board are getting the same Monday morning quarterbacking of our handling of Argonaut:

1. They say Argonaut should have been permitted to pull out of the state in December, the crisis then precipitated and Argonaut sued for breach of contract.

   Perhaps, but the judgment using our best knowledge, advice and skill was that:

   a. It was preferable to keep 4,500 physicians covered and in practice while corrective measures of the system were sought.
   b. Suit precipitating bankruptcy would remove coverage for each participating doctor and would help no one.

2. They say we should have protested the rate increase. In our judgment it was important not to jeopardize coverage for each of the 4,500 physicians recognizing that some of those in Class V would be pressed with large premiums. This has made it rough for some 800 while helping all 4,500 to stay in practice. The adverse effect is most severe in Philadelphia and the neighboring counties where premiums are indeed of such magnitude as to make some specialists either withdraw from practice, restrict their practices or continue without coverage.
3. They say a roll back or freeze of premiums should be sought through legislation.

   Any roll back is unrealistic and any "freeze" in the light of present trends will only serve to discourage all underwriters. In my opinion, pursuit of this avenue will be a costly and unproductive effort. We are better advised to concentrate our energies on the correction of the system which hopefully will permit all carriers to survive. Today, there is no answer for the member who is driven out of practice. Tomorrow with a strong unwaivering devotion there will be.

4. Note is taken of the resolution asking that neurosurgeons, anesthesiologists and orthopedic surgeons be permitted to attend all meetings of the Board of Trustees since they are affected by Board decisions. Every physician in this state is affected by Board decisions and those are equally important to each. They are made only after consultation and careful decision. I have no objection to having all Board meetings held as open meetings—open to all—but see nothing to be gained and if there is not confidence in your officers and your Board, it is preferable that they be replaced now rather than reducing the decision and actions of this Society to the gross inefficiency of mass action.

II. Legislation

House Bill 805 remains the only positive and progressive piece of legislation that has been introduced. With the Supreme Court decision upholding no-fault insurance and limiting the right to sue, 805 becomes stronger than ever. We must continue to push for its passage or the incorporation of its concepts into legislation. We do not care what the number of the final bill is nor who gets the credit but we do care greatly that the content of any bill which is proposed address the basic flaws in the current system.

805 has and will have opposition from trial lawyers and their cronies in the Legislature. We must recognize this and redouble our efforts to make our message clear that only 805 has the complete answer to the problem.

House Bill 1367 introduced by Speaker Fineman and supposedly with administration support is an effort to enact into law all of the travesties of the present system. It calls for a statute of limitations of six years on the coverlet of "pain and suffering," that juicy plum of profit for trial lawyers, but has no limit on anything else. It sets the contingency fee at 33-1/3 percent *plus* expenses and *in addition* to any award, guaranteeing a 40 percent to 50 percent increase in the cost to society. In establishing a monopolistic Joint Underwriting Association, it guarantees a source of payments, the cost to you in premiums being perpetuated and at an increasing rate. The bill must be exposed for the fraud it is and defeated.

Unhappily, we will have to work equally hard to knock down unsatisfactory bills as we will to get satisfactory changes enacted.

Where are we now? All house bills are before the Judiciary Committee. I have appeared before the committee twice. The letter campaign through the 805 Committees has had an effect, for Chairman Berson has proposed modifications of 1367 through Mr. Speaker. While these are a long way from being either effective or satisfactory, it is evident that the committee is concerned about getting our position.

In the Senate Bill No. 885 (Hankins) was introduced solely to get the Senate "in on the act." As introduced, it is a useless piece of legislation patterned after No. 1367 with but minor modifications. No. 837 in the Senate is largely House Bill 805. Senate Bill 907 was introduced yesterday and is being studied by us.

III. Action

A legislature dominated by lawyers will not develop corrective legislation if left to its own ways.

How do we effect passage of appropriate legislation?

1. Through a continuing campaign of letters—not from Medical Societies and doctors and their wives—but from the rest of society, members of your church or synagogue, everyone you can influence. The legislators know the doctors' opinions. They need the opinions of their other constituents.

2. By speaking to every group to which you can get yourself invited—church, Rotary, Kiwanis, PTA, etc., emphasizing first that you are being prevented from practicing properly, jeopardizing both the care of the individual and the public health, and second that the cost of the present system to patients is adding $5.00-$15.00/ hospital day and as much as $40.00 or more per patient

visit. Third, the cost of premiums is driving physicians out of practice. Whatever else we may do we must not stop on these.

3. Slowdowns and strikes. These are counterproductive. They have not effected appropriate legislation where tried—New York, California, and here in Pennsylvania. Their only effect is to call attention to the problem and this is now being effectively done. Above all else, it is our duty to care for the sick—not just emergencies—for to every patient his trouble, whatever it may be, is an emergency. By slowing down or striking we gain neither respect nor support.

What other alternatives are there? Remember our goal is to change the system. Our adversaries are those who profit by perpetuation of that system.

And now gentlemen, I come to the very momentous decision you must make. Appropriate measures to cope with the situation have been known to the Legislature since the introduction of 805 on March 19, 1975. Now a full three months later and despite personal conferences with the governor, the chairman of the Judiciary Committee and messages carried personally to every legislator by you we find discussion by the Legislature centering around a piece of legislation (1367), reportedly sponsored by the administration, which does nothing—nothing but legalize every travesty of the existing system. Recognizing that the Legislature is dominated by lawyers and many of them trial lawyers at that and having waited patiently and with restraints for positive action, we must now decide whether we should, or more precisely can, wait longer. We cannot. It is time to say we cannot fulfill our obligations to our patients and to society under the existing archaic, obsolete, cumbersome and self-serving system which has been developed by lawyers and the judicial system. I therefore recommend to you that you consider very critically and not necessarily favorably, each of the following that when this session ends, we will be unified in actions we can take ourselves with confidence independent of that system.

Your Board deliberated long and hard in a search for alternatives to the strike, recognizing that the alternatives are few and involve placing ourselves in jeopardy—unpleasant but much preferable to jeopardizing the patient. We must ask ourselves: Do I have the will and the courage to pursue principle—at the expense of personal loss? Is it time for civil disobedience adding our own rejection of a distorted and reprehensible legal system to those of others who have been driven to this approach? Let me digress for a moment to read you a letter from a man who not knowing of these recommendations has just the courage and conviction of which I speak:

Dear Dr. Crane:

I am enclosing checks for a total of $2,000 payable to the Pennsylvania Medical Society. I hope that these funds will be of assistance to you and the State Medical Society in resolving the crisis of malpractice premiums.

The source of this money is from attorneys' offices for my testimony. I had advised both of these attorneys' offices that I would appear as a witness at no personal financial gain to myself, but that a contribution of $1,000 in each case would be payable directly to the Pennsylvania State Medical Society for assistance in the current crisis.

My own strong feeling is to support the State Medical Society in our current crisis. I believe also that any testimony given by a physician should be at no personal financial gain to the physician. Perhaps the forthcoming session of the House of Delegates might consider this as a resolution. I look forward to seeing you on July 2nd.

Sincerely yours,

Charles C. Wolferth, Jr., M.D.
Professor of Surgery
Hahnemann Medical College and Hospital
Philadelphia

Your Board recommends for your consideration:

1. That until such time as adequate corrective legislation as contained in 805 is enacted:
   a. That physicians will continue to provide medical care but will withdraw as participants in all insurance programs will accept no assignments and will execute no payment forms until that time.
   b. No medical reports will be rendered by physicians to attorneys in cases relating to claims for medical disability.
   c. Physicians will refuse to testify on an adversary basis in cases claiming medical disability.
2. That this Society declare it unethical for a physician to accept a fee for medical testimony and that the PMS establish a system through which medical testimony will be furnished as a "friend of the court" but not on an adversary basis.
3. That physicians use a written agreement signed prior to acceptance of patients for settlement of patient dissatisfaction through binding arbitration.
4. That the PMS use its Medical Defense Fund to cover the legal costs of any meritorious "abuse of process" case on behalf of physicians who have successfully defended against a malpractice charge.
5. That the PMS set up a Society sponsored insurance program to be activated when meaningful legislation has been enacted.

Each of these carries risks to the individual physician and to the Society but knotting the legal and governmental process offers another route to gain effective legislation.

Our task is a difficult one. From the beginning I have promised you struggle and told you that results will come only as we present a united front and firm in the knowledge that our cause is just. More appropriate than ever but more than ever needing men of courage and determination to uphold it, let us again say with Hippocrates, "...I will use treatment to help the sick according to my ability and judgment. In whatsoever houses I enter, I will enter to help the sick and I will abstain from all intentional wrongdoing and harm...I will never divulge, holding such things to be holy secrets..."

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Emergency Physicians—A multi-hospital group of emergency physicians seeks members for full-time positions at major hospital emergency departments in Philadelphia and other areas of Pennsylvania. In addition to full-time emergency physicians, a physician director is sought for each emergency department. The group encourages professional and administrative autonomy in its member physicians. Financial arrangements are fee-for-service with minimum guarantee. Emergency-oriented educational programs for physicians are maintained by the group at no charge to its members. Compensation ranges from $40,000 to $[illegible],000 per year for 48 hours per week. Write: Department 650, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, Pa. 17043.

Emergency Room Physicians—2 needed to complete eventual emergency department of 3 full time physicians. Modern expanding 250 bed accredited hospital, 150 miles north of Pittsburgh. Small town, good schools, great hunting and fishing country. Sister M. Raphael, O.S.B., Administrator, Andrew Kaul Memorial Hospital, St. Marys, PA 15857; (814) 781-7500.

Psychiatrists, Physicians with Psychiatric Experience—Mental hospital in metropolitan area. Easy access to New York, Philadelphia, and close to Pocono resort area. Good salary with excellent fringe and retirement benefits. Pennsylvania license required. Contact: Henry Exbaum, M.D., Superintendent, Clarks Summit State Hospital, Clarks Summit, PA 18411. Telephone: (717) 586-2011.

Pathologist AP CP Certified—For 96 bed general hospital located in central Pennsylvania, County of Blair. Salary negotiable. Send resume to J. P. Kinney, Administrator, Nason Hospital, Roaring Spring, PA 16673; or telephone (814) 224-2141.

General Practitioner Wanted—for progressive industrial community of 7,500. 30 miles north of Pittsburgh on the Ohio River. Located in metropolitan area of 90,000. Beaver County Medical Center (275 beds) five minutes away with open staff. 3 other hospitals within eight mile radius. Four drug stores. Two colleges. 20 minutes from Pittsburgh airport. Contact Mrs. Mary Lou Keefe, 12 Stephen Phillips Homes, Monaca, PA 15061, or call (412) 378-8511, ext. 256 for Mrs. Keefe between 8:00 a.m. and 4:00 p.m.

Graduates of a Taiwan medical school seeking a partner in general practice for a neighboring community in north central Pa. Located close to hospitals, major cities, and airports. Will offer annual guarantee. Write Department 676, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

Anesthesiologist—Board Certified. To head department of seven C.R.N.A.s with a moderate surgical volume. 242 bed hospital in economically strong, progressive community of 60,000 in south central Pennsylvania, 60 miles east of Pittsburgh. Remuneration open. Contact T. R. Baranik, Administrator, Mercy Hospital of Johnstown, 1020 Franklin St., Johnstown, PA 15905; (814) 536-4461.

General Surgeon Wanted—Meyersdale (Somerset County), Pa. 52 bed general care-rural hospital. All modern equipment-facilities accredited-all agencies. 18,000 patient service area. Resort area-winter and summer sports. Applicants must: acquire Pa. license; be willing to practice general medicine; be Board Certified or eligible; be willing to direct OPD and emergency room. Hospital offers guaranteed income; fee for service practice; 1-year free hospital office space; necessary administrative support; complete Board, staff, employee cooperation. Contact: James M. Brown, Hospital Administrator, Meyersdale Community Hospital, Meyersdale, PA 15552.

Emergency Room Physician, Experienced—Career oriented physician to organize, staff and supervise a Department of Emergency Services, ultimately consisting of five (5) physicians. Salary dependent upon qualifications. 200 bed general hospital, located in Indiana, Pa., a university community, 1 hour driving distance from Pittsburgh, Pa. Reply to: M. C. Williams, M.D., Chairman, Recruitment Committee, Indiana Hospital, Indiana, PA 15701.

Board Certified or Board Eligible Psychiatrists needed at 951 bed modern NP Center; salary up to $36,000 per annum depending on qualifications; excellent fringe

benefits; nondiscrimination in employment; full and unrestricted license required; may be from any state; travel and transportation costs may be supported. Contact Chief of Staff, VA Hospital, Leech Farm Road, Pittsburgh, PA 15206, or telephone (412) 363-4900, Ext. 223 or 244.

Emergency Room Physician— Excellent opportunity for an experienced ER physician to join on the ground floor of a professional group. This is a 277-bed general, accredited hospital, located in a beautiful suburb of Philadelphia. For further information call or write T. A. Harrington, Administrator, Holy Redeemer Hospital, Meadowbrook, Pennsylvania 19046. Telephone (215) WI7-3000.

Anesthesiologist—Medical Director for departments of anesthesia and respiratory therapy. Position available immediately for 107 bed short term acute care JCAH hospital. Anesthesia department well equipped and staffed by three competent CRNAs. Respiratory therapy department performing pulmonary functions and blood gas studies. Fee for service or negotiable salary arrangement with benefits available. Contact Mr. Henry L. Gerber, Administrator, Annie M. Warner Hospital, Gettysburg, PA 17325; (717) 334-2121.

House Staff Physician—280 bed accredited hospital seeks Pennsylvania licensed physician for 40 hours per week plus two nights per week. Located in the beautiful suburbs of Philadelphia. Paid malpractice insurance, pension plan, hospitalization, sick leave, vacation, disability insurance and other attractive benefits. $28,500 per year. Call or write T. A. Harrington, Administrator, Holy Redeemer Hospital, Meadowbrook, PA 19046; (215) 947-3000.

Neurologist Wanted—Private Practice, Cherry Hill, N. J. Call (609) 429-7230.

Excellent Practice Opportunity—For family practice, internist, pediatrician, cardiologist, chest disease, and psychiatrist, northern Phoenix, population 75,000, new non-profit general and mental hospital to be built, also senior citizen complex, ideal climate. Contact John Hayman, Vice President, Deer Valley Medical Center, 2525 Greenway Rd., Phoenix, Arizona 85023.

Family Practice, Internist, Pediatrician—Needed in college town with drawing population of 25,000 located at intersection of I-79 and I-80. Growing area, clean air, good schools in Western Pennsylvania. All foreign graduates must have a permanent immigrant visa. Guarantee negotiable. Contact: Mr. J. A. Colaizzi, administrator, Grove City Hospital, Grove City, PA 16127; telephone (412) 458-7132.

Director of OB/GYN in 600 bed community hospital with full time university integrated residency. Salary guarantee plus allowance for small private practice. Must be Board Certified; prefer under age 45. Contact C. M. Rohrabaugh, M.D., Director, OB/GYN, Harrisburg Polyclinic Hospital, Harrisburg, PA 17105.

Emergency Room Physician—New 204 bed general hospital in Western Pennsylvania 55 miles north of Pittsburgh. Full time position. Hourly rate plus liability, life, health, workman's compensation, unemployment compensation, retirement, holidays, vacation, salary continuation for sickness or disability. Pennsylvania license required. Fishing, hunting, and other recreational opportunities on unpolluted Allegheny River. Contact: F. O. Robertson, M.D (412) 542-5404.

Internist/GP—Salary $30,000 range plus benefits. Located in Finger Lakes Region, gracious country living. Non-discrimination in employment. Malpractice insurance not necessary. Contact Chief of Staff, VA Center, Bath, NY 14810.

FP/GP for innovative family health center in north central Pennsylvania. Excellent salary and fringe. Teaching opportunity in F. P. residency. Rural area with convenient cultural and outdoor activities. Contact J. W. Montague, M.D., Medical Director, North Penn Family Health Center, Blossburg, PA 16912.

Emergency Room Physicians—Needed immediately to fill vacancy in group of four men. Pa. license required; 23,000 visits annually; growing community; good location in south central Pa.; 40 hr. wk.; competitive salary and fringe benefits, including malpractice insurance coverage. Call Administration (717) 761-0202.

Community Health Physician—Service to provide primary care for growing population; opportunities to be developed; south central Pa.; 40 hr. wk.; malpractice insurance coverage. Call Administration (717) 761-0202.

Full Time Emergency Room Physicians—147 bed acute care community hospital located in Philadelphia suburbs has full time positions for emergency room physicians. Growing community of over 80,000 with hospital emergency room visits exceeding 13,000 last year and an annual growth rate of 6-8% anticipated. Imminent construction of new emergency room facility planned. Salary negotiable. Reply to: Robert H. McKay, Executive Vice President, North Penn Hospital, 7th and Broad Streets, Lansdale, PA 19446; (215) 368-2100.

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obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Horace E. DeWalt**, Pittsburgh; University of Pennsylvania School of Medicine, 1920; age 78; died June 2, 1975. Dr. DeWalt was a member of the founders group of the American Board of Surgery and founder of the Allegheny County Health-O-Rama, a free screening examination for major diseases, which was used as a model for other areas. He was a fellow of the American College of Surgeons, a charter member of the Pittsburgh Surgical Society, and an associate fellow of the American College of Gastroenterology. He is survived by his wife and two sons.

• **Merrill B. DeWire**, Wyomissing; University of Pennsylvania School of Medicine, 1927; age 77; died May 24, 1975. Surviving are his wife and two sons.

• **Norman N. Macfarlane**, Paoli; University of Pennsylvania School of Medicine, 1925; age 78; died May 24, 1975. He is survived by a son and a daughter.

• **Willard C. Masonheimer**, Allentown; Univeristy of Pennsylvania School of Medicine, 1914; age 85; died May 29, 1975. A physician for 61 years, Dr. Masonheimer was president of the Lehigh County Medical Society in 1938, president of the Lehigh County Blind Association 1936-59, and chairman for several years of the state Association for Prevention of Blindness. He was credited for beginning the vision and glaucoma screening program and the Sergeant Seymour Eye Safety program in Pennsylvania. Dr. Masonheimer was a member of the American Urological Association and a fellow of the Academy of International Medicine. A daughter and a sister survive him.

• **Louis M. Orr**, Williamsport; New York University Medical College, 1933; age 67; died May 22, 1975. He was chairman of obstetrics at Divine Providence Hospital and a fellow of the American College of Obstetricians and Gynecologists, the American College of Surgeons, and the Academy of Psychoanalytic Medicine. He is survived by his wife, a son, and a daughter.

• **Charles Ira Pratt**, Coatesville; Hahnemann Medical College, 1914; age 87; died June 6, 1975. Dr. Pratt had practiced medicine for 56 years. He is survived by his wife and a son, Charles I. Pratt, Jr., M.D.

• **Allen Norman Safier**, Pittsburgh; University of Pittsburgh School of Medicine, 1929; age 71; died June 13, 1975. He is survived by his wife and two sons, one of whom is Joel Safier, M.D.

Joseph Bartone, Philadelphia; University of Naples Medical School, 1925; age 74; died June 6, 1975. Surviving are his wife, a daughter, and a son, Francis F. Bartone, M.D.

Stuart Mudd, Philadelphia; Harvard University, 1920, age 81; died May 6, 1975. He was involved in the development of the freeze-drying process for blood plasma which saved many lives during World War II. Dr. Mudd was a pioneer in the use of the electron microscope in biomedical research and was chairman of the National Research Council's committee on its biological applications. He was past president of the Society of American Bacteriologists, the Histochemical Society, and the International Association of Microbiological Societies. He is survived by his wife, two daughters, and two sons, one of whom is Harvey Mudd, M.D.

James R. Connolly, Hilton Head, S.C.; Georgetown University, 1936; age 70; died April 20, 1975. He practiced medicine in Pittsburgh for more than 30 years. His wife, a daughter, three sons, a brother, and a sister survive him.

Jacob Hoffman, Philadelphia; Jefferson Medical College, 1925; age 75; died May 15, 1975. He was clinical professor of obstetrics and gynecology at Thomas Jefferson University Hospital. His wife, a son, two daughters, a brother, and two sisters survive him.

Richard Shuman, Philadelphia; McGill University, Montreal, Canada, 1941; age 62; died May 16, 1975. He was professor of pathology at the Medical College of Pennsylvania. His wife and two sisters survive him.

George E. Thomas, Philadelphia; University of Pennsylvania School of Medicine, 1933; age 69; died May 22, 1975. He had practiced in Philadelphia for 42 years. The majority of his patients were the poor and the elderly and about ninety percent of his practice consisted of house calls. His wife, three daughters, and a son survive him.

DISPLAY
SHELVES

pennsylvania medicine

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THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON

OCT 16 1975

September 1975

1975 Highlights—year of crisis

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pennsylvania medicine

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September 1975 Volume 78, Number 9

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PENNSYLVANIA MEDICINE, established in 1897, is published monthly as the official publication of the Pennsylvania Medical Society. All original papers and correspondence should be directed to the Managing Editor. Subscription requests and changes of address should be sent to PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043. A subscription is $5.00 per year. Single issues are 50 cents. Second class postage is paid at Lemoyne, Pennsylvania 17043.

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OCT 16 1975

medigram

MEDICAL PROTECTIVE RATE INCREASE ANNOUNCED The largest writer of professional liability insurance in Pennsylvania, Medical Protective Co., has received Insurance Department approval to increase its premiums by 68 percent effective September 1, 1975. Commissioner William J. Sheppard said the increase will affect about 6,600 physicians and 4,000 dentists and will generate approximately $2.4 million in added premiums annually. The original request was for a 75 percent increase.

FURTHER MALPRACTICE RATE INCREASES REQUESTED The Insurance Department held public hearings August 21 on rate increase requests by the Insurance Services Office (ISO), a statistics gathering and ratemaking organization which submits rate filings for a number of insurance companies. One request is for a 250 percent increase in the base rate ($25,000/$75,000). The other request is for an average 410 percent increase in the increased limits rate applying to the portion of the premium for coverage in excess of the $25,000/$75,000 basic limits. ISO's increased limits rates are used by a majority of companies writing malpractice insurance in Pennsylvania, including Aetna and Argonaut. A. Reynolds Crane, M.D., in a letter to Insurance Commissioner William J. Sheppard, stated that "any favorable consideration by the department of the filings by the Insurance Services Office would be inappropriate and ill-timed." His letter urged a moratorium on professional liability rates until the Legislature's final action is known. Meanwhile, with the Legislature in recess, work has continued on the part of the State Society to seek amendments to improve H. B. 1367, a malpractice reform bill passed unanimously in the House of Representatives and currently under study by the Senate Insurance Committee. Senate leaders have promised prompt action on the legislation when the Legislature reconvenes September 22.

REQUEST TO SUSPEND ARGONAUT INCREASE DENIED Insurance Commissioner Sheppard denied the request of 100 physicians to suspend the Argonaut rate increase, but granted them a hearing to review the increase granted last spring. Originally scheduled for September 12, the hearing has been postponed while data are gathered.

SOCIETY PROTESTS CLINICAL LABORATORY RULES The Society has issued a formal protest to Health Secretary Leonard Bachman, M.D., stating that a regulation to implement the Clinical Laboratories Act published August 16, 1975 has no statutory authority. The Act itself specifically exempts the offices of physicians by defining a laboratory as an establishment organized primarily for performing tests. The regulation which is to become final 90 days after publication would severely limit the kinds of tests which may be performed in a physician's office unless the physician requests and obtains a license to operate a clinical laboratory. In a letter to Secretary Bachman, Society President Crane said, "The Department's action in this instance is patently illegal...The (Pennsylvania Medical) Society will not acquiesce to such extemporizing with the intent of the Legislature and will pursue such action as may be required to prevent your implementation of these regulations."

HEW WITHDRAWS DISPUTED REGULATIONS The medicare and medicaid utilization review regulations slated to become effective first on February 1 and then on July 1, 1975, have been withdrawn by the new Secretary of the Department of Health, Education, and Welfare, F. David Mathews. It was a major victory for the AMA which had petitioned the court for an injunction to prevent implementation and had won the delays leading to their withdrawal.

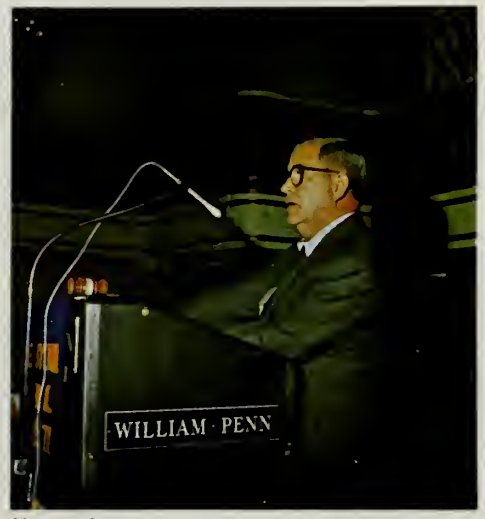
FINAL HSA DESIGNATIONS MADE The September 2, 1975 Federal Registe carried a list of final designations for Health Service Areas under Public Law 93-641. In Pennsylvania the counties are aligned as follows: AREA 1: Bucks, Chester, Delaware, Montgomery, Philadelphia; AREA 2: Berks, Carbon, Lehigh, Monroe, Northampton; AREA 3: Lackawanna, Luzerne, Pike, Schuylkill, Wayne, Wyoming; AREA 4: Adams, Cumberland, Dauphin, Franklin, Lancast Lebanon, Perry, York; AREA 5: Centre, Clearfield, Clinton, Columbia, Jefferson, Juniata, Lycoming, Mifflin, Montour, Northumberland, Synde Union; AREA 6: Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington, Westmoreland; AREA 7: Cameron, Clarior Crawford, Elk, Erie, Forest, McKean, Mercer, Potter, Venango, Warren; AREA 8: Bradford, Sullivan, Susquehanna, Tioga, plus the New York counties of Broome, Chenango, Tioga; AREA 9: Bedford, Blair, Cambria, Fulton, Huntingdon, Somerset. P.L. 93-641, the National Health Planning and Resources Development Act, combines three existing federal health programs: Hill Burton funding, regional medical progra and comprehensive health planning. All future federal health funding will be made available through health systems agencies which will be established in HSAs.

SOCIETY TESTIMONY OFFERED During the past month the Society offer testimony on two legislative matters affecting physicians. Abram M. Hostetter, M.D., vice chairman of the Commission on Education and Manpower, testified on proposed legislation to restructure and broaden the Bureau of Professional and Occupational Affairs, which contains the State Board of Medical Education and Licensure. Arthur H. Hayes, Jr., M.D., chairman of the Commissio on Therapeutics, testified on H.B. 473, which would permit pharmacist to substitute a generic drug for a physician's prescription. Dr. Hayes' testimony appears on page 59. Dr. Hostetter reminded the House Committee on Professional Licensure that proposed malpracti reform legislation provides that the State Board should receive funds to enforce the new Medical Practice Act strictly, and that the State Society supports this position.

SUPPORT CENTER FUNDED The Pennsylvania Medical Care Foundation (PMCF) has received funding to continue as a statewide support center for the development of Professional Standards Review Organizations (PSRO) until June 30, 1976. The federal contract awards the Foundation $153,992. Five PSROs in Pennsylvania which were previously granted conditional status by the Department of Health, Education, and Welfare, have been funded as follows: Allegheny PSRO-$493,451; Southwestern PSRO-$447,519; Southcentral PSRO-$288,527; Montgomery/Bucks PSRO-$240,209; and Philadelphia PSRO-$406,795.

HIGHLIGHTS - 1975

1975 will be remembered as the year of the Malpractice Crisis. No sooner had the gavel sounded closing the 1974 House of Delegates in Pittsburgh, than the first tremors of the impending crisis were received from the Argonaut Insurance Company. In November, Frank B. Hall & Co., broker for the program endorsed by the State Society, reported that



House Speaker John B. Lovette, M.D.

Argonaut wanted another rate increase of sizeable proportions. A few weeks later Argonaut also proposed restrictions on the program.

On the day of the January Board meeting, an attorney for Argonaut delivered the surprise ultimatum. Argonaut proposed to terminate its agreement to cover physicians in Pennsylvania on or before December 31, 1975, leaving more than 4,000 State Society members without professional liability insurance. Society attorneys said prospects were good that a suit could hold Argonaut to its five year contract. On February 28, 1975, the suit was filed in the Court of Common Pleas of Philadelphia. The

The Budget

The scene is the 1974 House of Delegates meeting in Pittsburgh. At the rostrum is George A. Rowland, M.D., Chairman of the Finance Committee. Gripping the dais with both hands he explains that the three-year-old $100 per member dues will no longer pay the bills. Inflation has eaten away the dollar. The Finance Committee worked on the budget. It held hearings and questioned Council chairmen. Nevertheless the total net tab comes to $1,400,678 resulting in a projected deficit of $203,728. Dr. Rowland concludes: "The Finance Committee Recommends that the 1975 annual assessment for active members be $125." Silence . . . and then the unexpected happens. Dr. Irving Williams from Union County asks whether the $25 maintains the status quo or increases Society activities. Dr. Rowland says the additional $25 maintains the status quo. Delegates react. Figures for higher amounts are heard. A few minutes later delegates vote the 1975 assessment at $150.

No sooner had they taken this prescient action than the malpractice cauldron began to bubble. By the January Board meeting, a special budget was necessary to wage the malpractice battle. It began at $126,000. Twice later it was revised upward until it reached its present amount of $432,000. Without the $270,000 in extra money which the House provided, the Society would have been severely handicapped.

prediction of Society attorneys proved to be correct; the contract was enforced. The price, however, was a rate increase, which the Society could only whittle down from 256 percent to 207 percent.

At its January meeting the Board of Trustees delegated day to day direction of the malpractice crisis to an ad hoc committee chaired by A. Reynolds Crane, M.D., Society president. Other members of the committee are David S. Masland, M.D., president elect; J. Joseph Danyo, M.D., chairman of the Commission on Professional Liability Insurance; and Donald E. Harrop, M.D., chairman of the Council on Governmental Relations and of the Commission on Forensic Medicine.

This committee, with the aid of the Society's legal counsel, prepared a malpractice reform bill embodying the major goals of the State Society. Its introduction coincided with the Society's testimony before Insurance Commissioner William J. Sheppard in Philadelphia on March 18. While Dr. Crane was testifying in Philadelphia before the commissioner Representative William Shane and other legislators introduced House Bill 805 in Harrisburg.

For the next four months Pennsylvania physicians rallied around the principles proposed in the bill. A series of special councilor district meetings in early April gave members a briefing on the proposals. The Society launched an intensive public information campaign spearheaded by a full page ad in every Sunday newspaper in the state. A pamphlet was mailed to members for distribution to patients. Model speeches, visual aids, additional ads, and radio announcements were distributed. Ad hoc committees were organized in each county and specialty society.

The Woman's Auxiliary organized similar committees. Leadership was briefed at special meetings in Harrisburg and then went home to organize a letter writing campaign to legislators which produced more than 50,000 letters. Finally on July 2 and 3 the House of Delegates met in Harrisburg in emergency session to deal with the crisis.

As the public information campaign gathered momentum, newspapers, radio and television

THE BOARD OF TRUSTEES

Board of Trustees activity took long hours and was difficult in this year of crisis. Shown on the cover of this issue is the Board in action. Members are: First District—Donald R. Cooper, Philadelphia; Second District—Leroy A. Gehris, Reading; Third District—Ralph K. Shields, Bethlehem; Fourth District—George A. Rowland, Millville; Fifth District—Raymond C. Grandon, Harrisburg; Sixth District—Joseph M. Stowell, Altoona; Seventh District—Kenneth L. Cooper, Williamsport; Eighth District—David J. Keck, Fairview; Ninth District—Cyrus B. Slease, Kittanning; Tenth District—David W. Clare, Pittsburgh; Eleventh District—William C. Ryan, Somerset, and Twelfth District—Orlo G. McKoy, Canton.

The current Board also includes as voting members President A. Reynolds Crane, President Elect David S. Masland, Vice President William J. Kelly, and Immediate Past President Robert S. Sanford. Sitting with the Board as nonvoting members this year are John B. Lovette, speaker of the House of Delegates; D. Ernest Witt, vice speaker; and G. Winfield Yarnall, Camp Hill.

Special house session reflects delegates' concern

THE GRAVITY of the issue before the special session of the Society's house of Delegates July 2 and 3 is reflected on the faces of physicians as they listened to the debate and spoke to fellow delegates.

Left to Right are Robert H. Craig Jr. of the staff, J. Joseph Danyo, M.D., David S. Masland, M.D., and A. Reynolds Crane, M.D., members of the ad hoc committee

stations began to devote an increasing amount of coverage to the malpractice crisis. County society officers were interviewed. Almost daily there were stories of physician activity on the malpractice crisis nationwide.

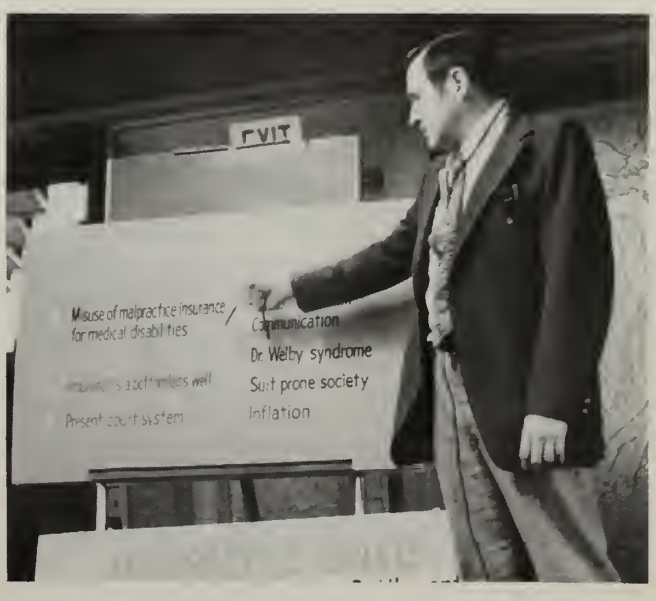
Meanwhile, the administration was preparing its own malpractice bill. Governor Milton J. Shapp announced the bill at his press conference on May 14 and on June 3, Speaker of the House Herbert Fineman and 31 other members of the House of Representatives introduced House Bill 1367, "The Health Care Services Malpractice Act."

Sixteen days later in Philadelphia the Society testified on the Fineman bill before the House Judiciary Committee. Dr. Crane told the committee that H.B. 1367 as introduced would legalize the existing faults in the tort system and at the same time would destroy the remaining private malpractice insurance industry in Pennsylvania with a mandatory joint underwriting association (JUA). Although in every instance Dr. Crane compared the shortcomings of the Fineman bill with the real reforms in H.B. 805, it became apparent that an amended H.B. 1367 would be the vehicle to

move in the House.

The House Judiciary Committee began working on the bill and action became apparent about July 7 during the last two weeks of the session. The Judiciary Committee reported H.B. 1367 with a number of amendments. After brief stops in the Appropriations Committee and the Rules Committee, the bill came to the floor on Thursday, July 17.

House leadership pressed hard that afternoon and evening for action, but members balked. Unprepared to debate the complicated issue, they delayed by introducing amendments, some 150 in all. After a brief try Friday morning the House adjourned for the weekend with H.B. 1367 slated for action on Monday, July 21.



Witnesses shown on these pages testify on House Bill 1367 before a combined hearing of the House Judiciary Committee and the Subcommittee on Insurance of the Consumer Protection Committee at Temple University in Philadelphia on June 19, 1975

As promised, the House began debate on H.B. 1367 on Monday. Late at night on July 21, after some nine hours of debate, the House unanimously passed a much amended H.B. 1367. When it left the House, the bill had more substance than when it entered, but was still not up to State Society standards. It provided for 12 screening panels to hear all malpractice cases. The panels, composed of two physicians, two lawyers, and one layman, to be appointed by the governor, are empowered to determine the existence of malpractice and to make awards, but the decisions are not binding. The bill does provide, however, that all of the evidence and findings, and the award, will be admissible in any subsequent court trial. The statute of limitations was drawn at an absolute seven years. The bill attempts to define informed

consent. It states that promises to cure must be in writing. The mandatory JUA was replaced with an assigned risk plan and a standby JUA. The most intriguing amendment puts a limit of $100,000 liability on the part of any physician's insurance company, with the remainder of any judgment to come from a special state administered contingency fund financed by up to a 10 percent surcharge on malpractice insurance premiums.

Was the amended bill acceptable? This was the question following the House action. Meanwhile, the Senate was preoccupied with appointments, teachers' retirement, and busing. Chances were dim that the Senate would deal

with malpractice before leaving for summer recess. Finally on July 24, on their way out the door, Senators referred H.B. 1367 to the Senate Insurance Committee.

Although the Senate officially was on vacation, committee work continued. The Society focused its attention on the Senate Insurance Committee which met to consider technical amendments on July 30. During

August the State Society continued to work with the Senate Insurance Committee seeking amendments to make H.B. 1367 more acceptable. These included a shorter statute of limitations and improved informed consent language.

While the Society focused its attention on long range reform of the law, a group of physicians in Philadelphia sought immediate

relief from the 207 percent rate increase granted to Argonaut in April. With the Society restrained by its desire to maintain coverage for its membership, this group, calling itself the Pennsylvania Medical Malpractice Crisis Committee, retained legal counsel and petitioned Insurance Commissioner William J. Sheppard to re-examine the Argonaut rate increase. The matter is pending at this time.

The need for rapid policy decisions in the malpractice crisis led the Board into a year of extraordinary activity. The Board, which normally meets seven times a year, met in ten of the past twelve months. New members of the Board elected by the 1974 House are Joseph M. Stowell, M.D., Altoona, representing the Sixth District, and David W. Clare, M.D., Pittsburgh, representing the Tenth District. Cyrus B. Slease, M.D., Kittanning, of the Ninth District, was re-elected chairman of the Board. George A. Rowland, M.D., Millville, of the Fourth District, was elected vice chairman.

Although every action of the Board affects Society policy, some decisions in 1974-75 assume special significance:

The malpractice crisis was the top priority. In this regard, the Board filed suit against Argonaut and authorized legislative action. In

April, trustees held special councilor district meetings across the state to inform members about action on the malpractice crisis.

More than 800 physicians and auxiliary members attended the briefings. In a telephone conference on June 2 the Board called an emergency session of the House of Delegates for July 2 and 3 to consider the crisis. Later in July the Board put out a second call for the House to return to Harrisburg but rescinded the call after leaders in the Senate promised prompt action in September. The

R. William Alexander, M.D., Chairman of the Officers' Conference Committee

Left is David S. Masland, M.D. President Elect, speaking on the malpractice crisis -

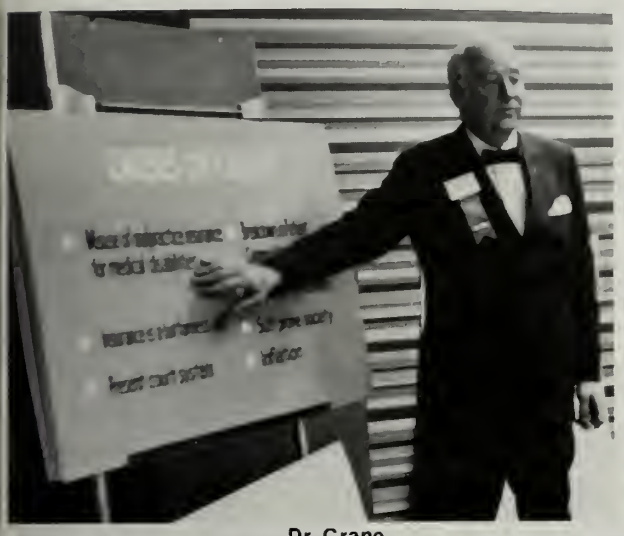
Below, left to right, are Leroy A. Gehris, M.D., Second District Trustee; Donald E. Harrop, M.D., chairman of the Council on Governmental Relations and member of the Ad Hoc Committee; and Robert H. Craig Jr., Director of Governmental Relations.

Board also approved a special $432,000 budget to pursue the malpractice problem.

The Board adopted new waiver and due process rules for the continuing education requirement and approved specialty society recertification in lieu of the AMA Physician's Recognition Award (PRA).

The 1975 Officers' Conference saw the first Donaldson Memorial Lecture delivered by Harry Schwartz, author of "The Case for American Medicine," winner of the AMA's Distinguished Service Award, and editorial writer on leave from the *New York Times*. The lecture is named after the late Walter F. Donaldson, secretary of the Society for 34 years and editor of PENNSYLVANIA MEDICINE for 17 years. Dr. Schwartz lectured on the problems of Britain's National Health Service. Held in conjunction with the 1975 Officers' Conference

Officers' Conference story seen by camera



Dr. Crane

Attentive audience

Dr. Ryan waits to speak

Senator W. Louis Coppersmith

Congressman H. John Heinz

was a Speakers' and Leadership Training Seminar with faculty supplied by the AMA. Twenty-five physicians took the eight hour, eight credit course. A similar course will be offered in conjunction with the annual meeting of the House of Delegates. State and federal health issues were discussed by Senator W. Louis Coppersmith, of Johnstown, chairman of the Pennsylvania Senate Public Health and Welfare Committee, and Congressman H. John Heinz, III, of Pittsburgh. Central to the conference, however, was the malpractice issue covered by Drs. Crane and Danyo and by Elliot L. Sagall, M.D., Boston, president of the American Society of Law and Medicine.

The Council on Education and Science, under the chairmanship of James A. Collins, Jr., M.D., persuaded the AMA to simplify reporting of the Physician's Recognition Award (PRA). Under the new rules, State Society members will be able to apply to the AMA for the PRA as soon as they have the necessary 150 hours. The deadline for the education requirement is now June 30, 1976. The Council also revised its PRA waiver and appeal procedures. Acceptable in lieu of the AMA award is specialty society recertification. The council offered two additional practice management courses. To date, 235 physicians have attended these seminars. Two seminars for residents, entitled "Establishing Yourself in Medical Practice," were held and both were filled to capacity. The council published a comprehensive report on medical manpower in Pennsylvania and followed this with specific recommendations to increase the number of primary care physicians

in Pennsylvania. A revised position on marihuana was approved by the Board in August and referred to the House. The Commission on Therapeutics established by the 1974 House of Delegates was activated. Its chairman testified on August 6 before the House Committee on Health and Welfare regarding H.B. 473, the "Generic Drug Substitution Bill."

For the Council on Medical Service under the chairmanship of Henry H. Fetterman, M.D., this was the year after Plan C. The storm surrounding Blue Shield's new fee schedule plan subsided in January when the Council, Blue Shield, and the Society's Board agreed on language to implement the annual updating mandated by the 1974 House of Delegates. It was June, however, before the Insurance Department approved test marketing of Plan C to selected large groups. The plan calls for periodic updates of fee schedules and premiums and includes income limits of $6,000 for an individual and $12,000 for a family.

In 1974, delegates said they wanted a look at the medicare prepayment utilization review screens. After months of negotiations a 300-page document was delivered to the Council on Medical Service. Explanation of the screens will appear in PENNSYLVANIA MEDICINE. The Council also monitored two Blue Shield experimental programs: "Prepayment Claims Review by Diagnosis" and "Payment by Diagnosis."

Most of the Council's activity, however, centered in two of its commissions. Evaluation of Argonaut's performance and demands fell upon the Commission on Professional Liability Insurance chaired by Dr. Danyo. The commission met four times during the year to

review the changing status of the PMS-Argonaut-Frank B. Hall relationship. One result was a reduction by Argonaut in its rate request from 256 percent to 206 percent. Most recently the commission has been investigating the feasibility of a Society owned malpractice insurance company.

The Commission on Health Planning chaired by John L. Steigerwalt, M.D., spearheaded the Society's response to the new Federal Health Planning and Resources Development Act, P.L. 93-641. The field contact staff polled county

societies regarding Health Service Area boundaries. The consensus was to recommend the boundaries of areas established for the twelve Professional Standards Review Organizations. Secretary of Health Leonard Bachman, M.D., however, developed the administration's proposal for eight areas which Governor Shapp transmitted to the Department of Health, Education, and Welfare (HEW). The commission alerted county societies and expressed the Society's objections to the Regional Office of HEW and to Secretary Caspar Weinberger. With the announcement by HEW of area boundaries in Pennsylvania, the commission's attention turned to the composition and formation of the Health Systems Agencies, the organizations which will administer future federal health funds in each area.

The council's 21 advisory review panels received requests from third parties for review of 237 cases. These panels render advisory opinions as to the appropriateness and medical necessity of reported services and the reasonableness of fees charged. Limited in the past to administrative costs, the Board approved a policy change in January calling for a charge of $35 per hour per physician for attending meetings to be made to the submitting carrier.

For the chairman of the Council on Governmental Relations, Donald E. Harrop, M.D., it has been an action packed year because of his membership on the ad hoc malpractice committee. Conversely, regular

James A. Collins, M.D., chairman, Council on Education and Science

council activity proceeded at a slower pace reflecting limited attention by the Legislature to health bills. Most health legislation introduced in 1975 was carried over from last year. For example, comprehensive health care legislation died in 1974 when the Legislature adjourned. It returned this year in Senate Bill 10 and House Bill 853. Again the Society testified against these bills, primarily because they give sweeping unrestricted powers to the Department of Health. Other legislation requiring council attention included bills on ambulance regulation and emergency medical services, physicians' assistants, and generic prescribing.

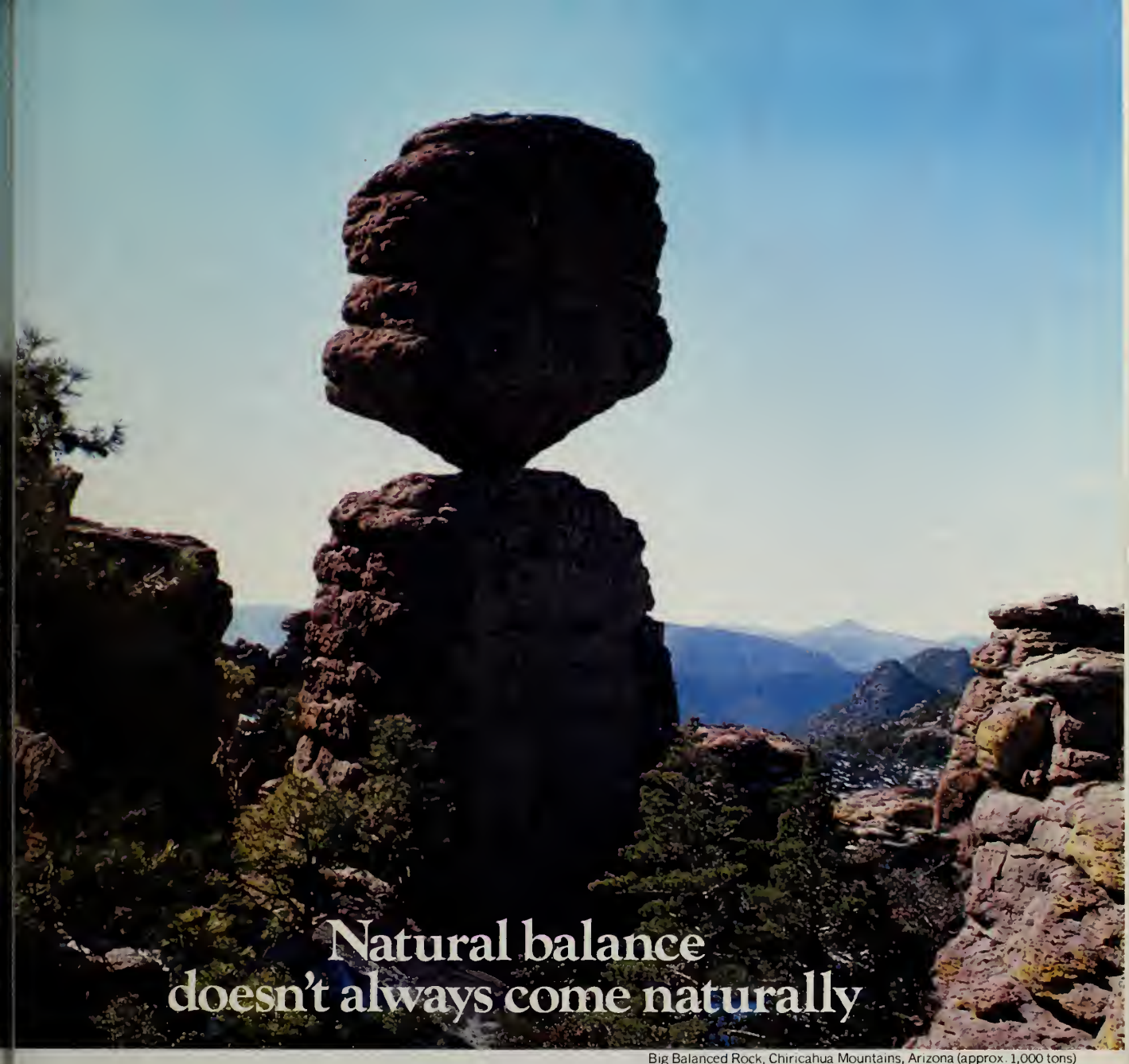
The Council on Professional Relations and Services under the chairmanship of Ulysses E. Watson, M.D., successfully concluded the recruitment campaign for the Pennsylvania Medical Cooperative. The Board, at its March meeting determined that the Cooperative, with 1,812 paid members, should begin. Subsequently, the articles of incorporation were filed in Washington, D.C., the membership certificates issued, a manager hired, and a warehouse rented. The Cooperative's Board of Directors expects business to begin in September.

Ulysses E. Watson, M.D., chairman, Council on Professional Relations and Services

Jonathan E. Rhoads, M.D.

The Council's other principal activity has been membership recruitment which has been limited to direct mail campaigns but which will involve in the coming months an experimental ambassador-type campaign using volunteers from the county societies to recruit new members.

Jonathan E. Rhoads, M.D., of Philadelphia has been named recipient of the Pennsylvania Medical Society's highest award, the Distinguished Service Award. Surgeon, teacher, scholar, and medical statesman, Dr. Rhoads is being honored "for his service to the science and art of medicine and for his life and activities, reflecting great credit on his profession." Dr. Rhoads is presently professor of surgery at the University of Pennsylvania School of Medicine and a member of the surgical staff of the Hospital of the University of Pennsylvania.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

Found useful in the management of vertigo* associated with diseases affecting the vestibular system.

Can relieve nausea and vomiting often associated with vertigo.*

Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.

Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.

Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

SUMMARY OF PRESCRIBING INFORMATION

INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

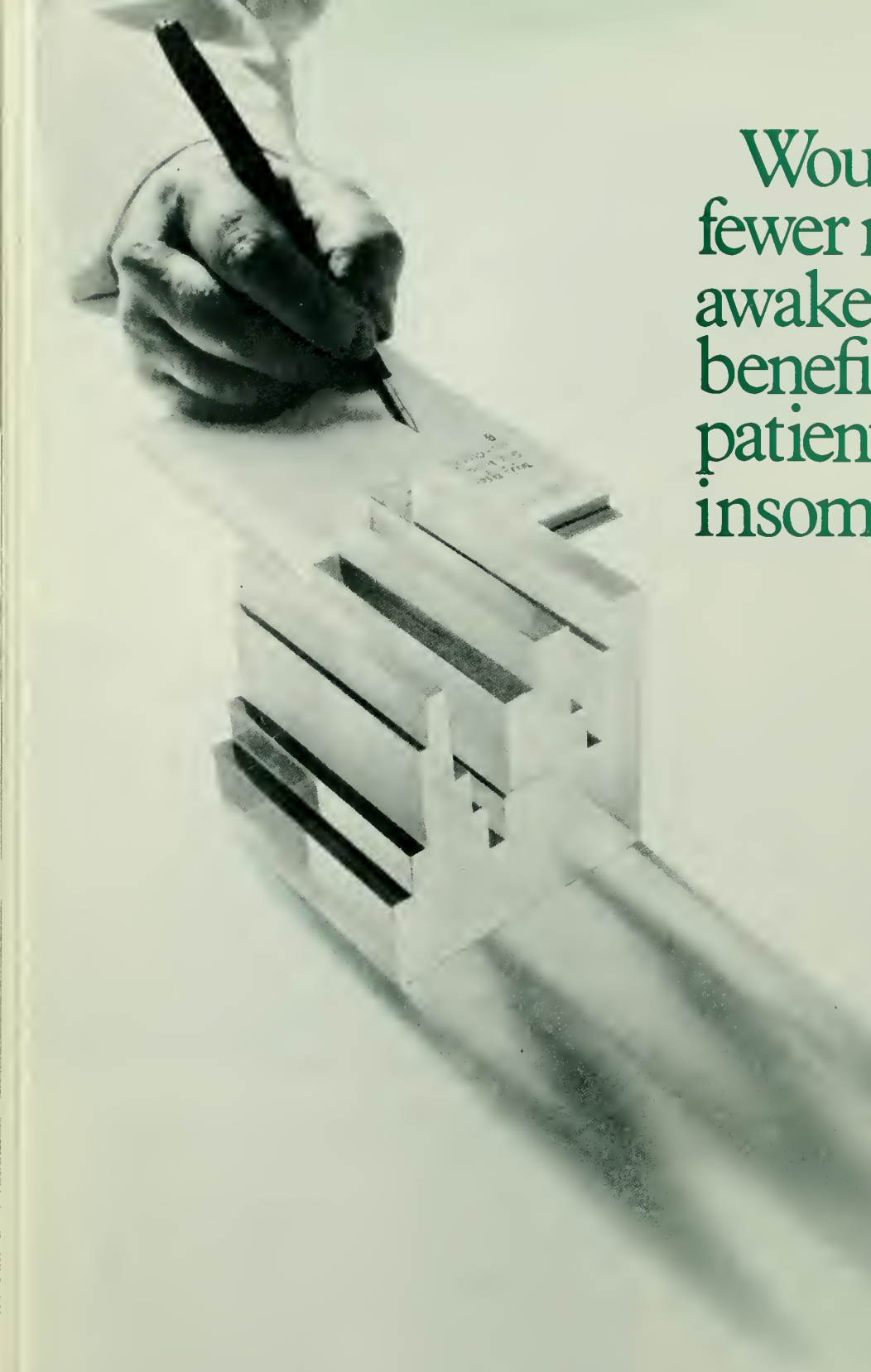
Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

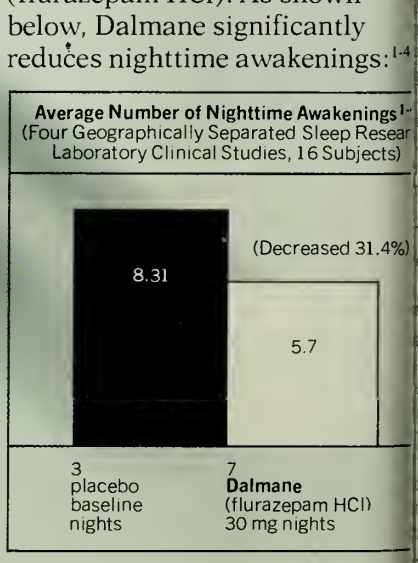
Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*



Would sleep wit fewer nighttime awakenings benefit your patients with insomnia?

Highly predictable results for your patients with trouble staying asleep...

...can be obtained with Dalmar (flurazepam HCl). As shown below, Dalmane significantly reduces nighttime awakenings:[1-4]



d for those with trouble
g asleep or sleeping
n enough...

Dalmane (flurazepam HCl) delivers excellent results. ically proven in sleep research atory studies: on average, within 17 minutes that lasts hours.[5]

lmane (flurazepam HCl)
latively safe, seldom
es morning "hang-over"...

and is well tolerated. The l adult dosage is 30 mg *h.s.*, with elderly and debilitated nts, limit the initial dose to g to preclude oversedation, ness or ataxia. Evaluation of ible risks is advised before cribing.

RENCES:

acan I, Williams RL, Smith JR: The aboratory in the investigation of sleep ep disturbances. Scientific exhibit at 4th annual meeting of the American iatric Association, Washington DC, -7, 1971

st JD Jr: A system for automatically ing sleep. Scientific exhibit at the nnual Clinical Convention of the can Medical Association, Boston, -Dec 2, 1970; and at the 42nd annual fic meeting of the Aerospace Medical ation, Houston, Apr 26-29, 1971

el GW: Data on file, Medical Depart- Hoffmann-La Roche Inc., Nutley NJ

ent WC: Data on file, Medical Depart- Hoffmann-La Roche Inc., Nutley NJ

a on file, Medical Department, ann-La Roche Inc., Nutley NJ

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prescribing Dalmane (flurazepam please consult complete product ation, a summary of which follows:

tions: Effective in all types of insomnia terized by difficulty in falling asleep, nt nocturnal awakenings and/or early ng awakening; in patients with recurring nia or poor sleeping habits; and in or chronic medical situations requiring sleep. Since insomnia is often transient termittent, prolonged administration is lly not necessary or recommended.

indications: Known hypersensitivity azepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

Depend on highly predictable results with

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

specifically indicated for insomnia

Objectively proved in the sleep research laboratory:
- **sleep with fewer nighttime awakenings**
- **sleep within 17 minutes, on average**
- **sleep for 7 to 8 hours, on average,**

with a single *h.s.* dose.

ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Opinion & Dialogue

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration

Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

The idea of a so-called patie package insert has been around a long time. Many physicians alre use written instruction sheets to provide patients with informatior about the drugs they are taking. A some physicians give verbal instr tions; but in too many instances these are what I call eye-glazing e ercises. I have seen patients sit w glazed eyes listening to a rapid-fi lecture by a hurried physician wh has 20 people out in his waiting room. These patients aren't giver sufficient understanding and the fore do not follow instructions. Sc think the idea of an official packa insert for patients is a good one. Perhaps we should really think of this kind of information simply as extension of drug labeling.

The benefits of patient involvemer

Many physicians may not re ize how frequently a patient obtai his drug information from Aunt Tillie or the next door neighbor. A this information is almost alway bad or irrelevant to the case at ha Furthermore, the incentive to go along with a prescribed program slim if the only reading matter th patient receives, along with his pi scription, is a bill.

As an educator I am impres by the principle that the best way get someone to do something is t involve him in the process. So the

I think there are advantages well as some real disadvantages i a patient package insert. When yc begin to use semi-medical or mec cal terms to describe complicatio or possible sequelae of disease or treatment, you may frighten the p tient—particularly since the more highly sophisticated patient is not the one who is going to read the ir sert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a packa insert will probably give the patier better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligati to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of seriou side reactions—to know what the real dangers are. But it doesn't do bit of good to indicate that a patie on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may pos sibly outweigh the potential good.

purpose of drug information
e patient is to get his cooperan following a drug regimen.

aration and distribution of nt drug information

We would hope to amass inforon from physicians, medical eties, the pharmaceutical industnd centers of medical learning. ultimate responsibility for unilabeling must, however, rest the Food and Drug Administra-There is nothing wrong with agency saying, "this informas generally agreed upon and efore it should be used," as long ur process for getting the inforon is sound.

Distribution of the information roblem. In great measure it d depend on the medication in tion. For example, in the case injectable long-acting progesne, we would think it mandatory sue two separate leaflets—a t one for the patient to read begetting the first shot and a long o take home in order to make a sion about continuing therapy. is case, the information might ut directly on the package and emovable at all. But for a medin like an antihistamine this mation might be issued sepay, thus giving the physician the n of distribution. This could erve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

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the doctor can remove that fear
) or 30 minutes of conversation.

I'm not suggesting that we hold any information from the ent because, first of all, it would tally dishonest and secondly, it d defeat the very purpose of the t. I do think that a patient on the control pill should know about ncidence of phlebothrombosis.

If you're going to tell a patient ncidence of serious adverse reons, then you have to tell him a concerned medical decision made to use a particular medin in his situation after careful ideration of the incidence of plications or side effects.

tionally unstable patients pose ecial problem

There are patients who, be- e of severe emotional problems, d not handle the information ained in a patient package in- Yet if we are going to have a age insert at all, we just can't two inserts. I think we might ly have to tell the families of e patients to remove the insert the package.

l implications of the patient age insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

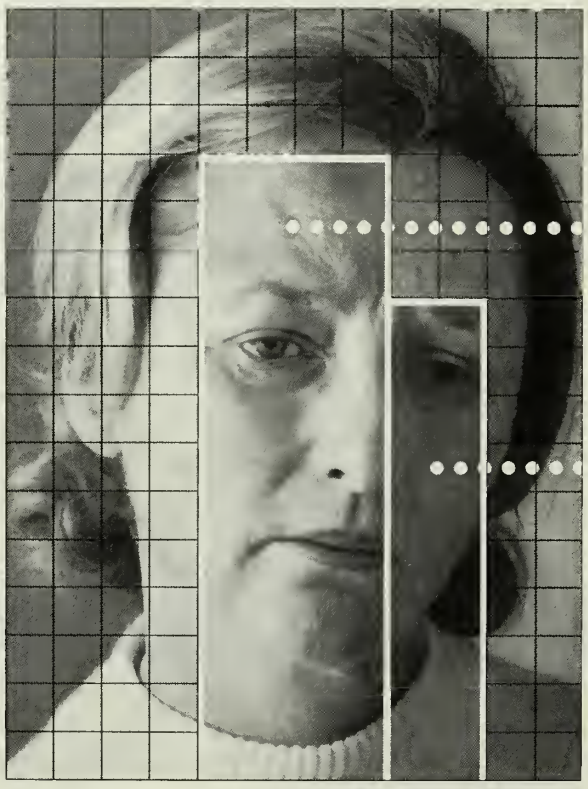
The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequen and/or severity of grand mal seizures m require increased dosage of standard an convulsant medication; abrupt withdraw may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous in gestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) hav occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Kee addiction-prone individuals under carefu

respond to one

According to her major
ptoms, she is a psychoneu-
t patient with severe
iety. But according to the
ription she gives of her
ngs, part of the problem
sound like depression.
is because her problem,
ough primarily one of ex-
ve anxiety, is often accom-
ed by depressive symptom-
ogy. Valium (diazepam)
provide relief for both—as
excessive anxiety is re-
d, the depressive symp-
associated with it are also
relieved.

There are other advan-
s in using Valium for the
agement of psychoneu-
anxiety with secondary
essive symptoms: the
hotherapeutic effect of
um is pronounced and
l. This means that im-
cement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

illance because of their predisposi-
habituation and dependence. In
ancy, lactation or women of child-
ng age, weigh potential benefit
st possible hazard.

e utions: If combined with other psy-
opics or anticonvulsants, consider
ully pharmacology of agents em-
d; drugs such as phenothiazines,
tics, barbiturates, MAO inhibitors
ther antidepressants may potentiate
ion. Usual precautions indicated in
nts severely depressed, or with latent
ssion, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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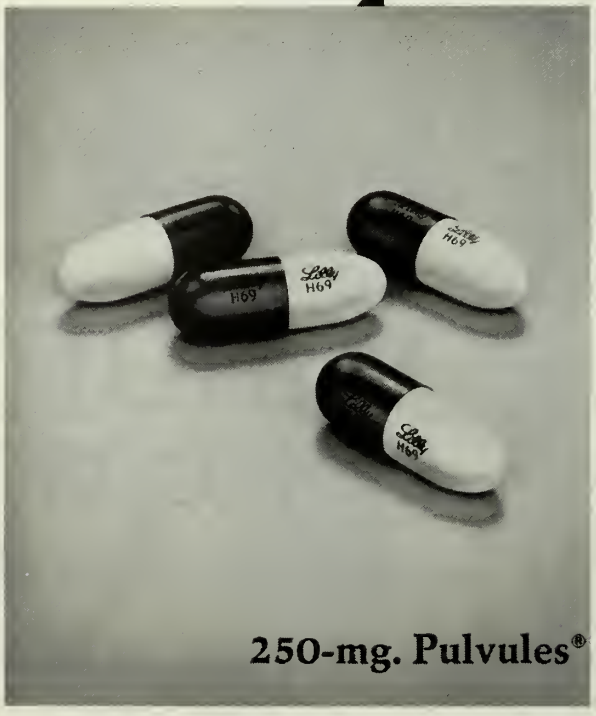
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

easy to take



Keflex®
cephalexin

Lilly

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

500738

president's page

)r. Crane points to progress; work to be done

As the time arrives to relinquish the privilege of the President's 'age there are a few comments that may be made with due llowance for the lag time between "pen and press."

The Legislature reconvenes on September 22 and at that time *ve* will know the extent to which the *factors in the malpractice risis* as detailed in my letter of August 7 have been addressed. We nust continue to pursue legislation which will effectively control ne cost factors and permit the care of patients without harassment eeping the tenets of 805 as our goal.

The poll of *Argonaut Insureds* mandated by the House has been completed. Most physicians feel that the premium paid does iot match the protection offered (Yes-572, No-897), a situation iot peculiar to Argonaut insureds. To the question, "Shall PMS eek a rollback in Argonaut premiums?" the response is yes-462, io-1036. The burden borne by the high risk specialties in metro-olitan Philadelphia is recognized, but insurance premiums will be ontrolled only as reason is brought to bear on awards, legal costs nd precise definition of the malpractice concept. It should again e emphasized that our concern is to maintain coverage for 4400 Argonaut insureds while striving to achieve premium relief for all hysicians as quickly as possible through appropriate legislation.

Equally ominous to quality medical care is *governmental bu-eaucratic rule and regulation* which is rapidly moving medicine owards becoming the first federally regulated profession (*Forbes Magazine,* 7-15-75). You sense this through the morass of regula-ions dealing with medicare, medicaid, PSRO, HMO and CHP egislation. It is on your doorstep in finite form in Pennsylvania where the Department of Health has interdicted the performance of the CEA Procedure despite its usefulness in following the management of selected cancer patients.

Meg Greenfield, writing in *Newsweek* (8-4-75) put it well: 'Bureaucrats don't have the guts to substitute good judgement or bad rules and the rest of us don't have the confidence - either in hem or each other - to make the bureaucrats try." These words should challenge all of us to make this Society into a strong coalition capable of effective confrontation.

For your support and encouragement through the year I am grateful. Though goals are not yet achieved they are identified and will be attained as we maintain our conviction. My prayer is for your success.

A. Reynolds Crane, M.D.
President

Dr. Koop to address prayer breakfast

Dr. C. Everett Koop, surgeon-in-chief at the Children's Hospital of Philadelphia, will be the guest speaker at the third annual Prayer Breakfast, sponsored by the Committee on Medicine, Religion and Bioethics, to be held Thursday, November 6, 8:00 a.m., at the Host Inn, Harrisburg.

Dr. Koop came to worldwide attention when he led the team of 18 doctors and 5 nurses which separated the Siamese twin girls, Alta and Clara Rodriguez, in September 1974 at the Children's Hospital. He has been surgeon-in-chief at the Children's Hospital since 1948 and editor-in-chief of the *Journal of Pediatric Surgery* since its founding in 1965 and is professor of pediatric surgery at the University of Pennsylvania School of Medicine.

Dr. Koop's philosophy enables him to do his work. In a recent article he wrote for "Guideposts" magazine, he said, "I'm able to look at tragedies . . . and see those tragedies in the light of God's Will. And I can understand my own role better. If I had to go through life thinking that all the day-to-day decisions I make about patients depended on chance or on my own infallibility, I'd become very discouraged. But I know I'm not fighting a battle in the operating room all by myself."

All members of the Pennsylvania Medical Society and their wives, in addition to all others, are invited to attend. The cost is $4.00 per person.

Please contact Miss Joselyn Loy at Society headquarters if you plan to attend the Prayer Breakfast.

Sports medicine subject

The Center for Sports Medicine of Temple University is offering one and two week mini fellowship programs to physicians and orthopedic surgeons with an interest in the health of athletes.

The course consists of participation in the daily activities of the center, which serves 50 to 75 outpatients daily, and taking part in 7 to 10 elective surgical procedures, including knee arthroscopy, per week.

The mini fellowship program will run consecutively from September 1, 1975 through June 30, 1977. The fee is $125 a week and participants will be eligible for 40 hours of approved continuing education credit.

Inquiries should be addressed to Dr. Torg at the Center, 3401 North Broad St., Philadelphia, PA 19140.

The Society 1975-76 Roster is now available to members. The contents of the Roster includes component county society officers, county society members with their addresses and specialty codes, and an alphabetical list of members showing county affiliation.

PMS members may obtain a complimentary copy by contacting Society Headquarters, 20 Erford Rd., Lemoyne, PA 17043. Additional copies are $15.

MEMBERS of the Allegheny and Westmoreland County Medical Societies met recently with their legislators to discuss malpractice insurance legislation. Shown above, left, are Laibe Kessler, M.D., and L. David Edgar, M.D.; on the right, Dr. Kessler talks with Harry Serene, M.D., and David W. Clare, M.D., Tenth District Trustee. In the photo to the left are Representative James Kelly, Bernard Cohen, M.D., and James Dull, M.D.

Medicare prepayment screens now available

The Pennsylvania Medical Society's Council on Medical Service has received from Pennsylvania Blue Shield the Medicare Prepayment Utilization Review Screens which are in use prior to payment to determine whether the services rendered exceed predetermined norms. Delivery of the screens was delayed pending authorization by the Region IV office of the Department of Health, Education, and Welfare.

Listed below are the various computer screens utilized by Pennsylvania Blue Shield to detect services, on a per patient basis, which exceed predetermined norms. Services exceeding these norms are reviewed in accordance with its claims processing review system. Further details are available from the Office of Government Services, Pennsylvania Blue Shield, Camp Hill, PA 17011.

- Pathology services in excess of $30 per calendar month.
- Medical services in excess of $600.
- In-hospital psychiatric services in excess of $750.
- X-ray charges in excess of $100.
- In-hospital claims in excess of 25 visits.
- Claims for those beneficiaries who have previously been identified as a Chronic Renal Disease (CRD) Beneficiary, a Disabled/CRD Beneficiary, or Over 65/CRD Beneficiary.
- Nursing home visits in excess of one per calendar month.
- Home visits in excess of four per calendar month.
- Skilled nursing facility visits in excess of four per calendar month.
- Injections in excess of four per calendar month.
- Office visits in excess of four per calendar month.
- Arthrocenteses exceeding 12 per year.
- Nerve blocks in excess of three per year.
- Routine foot care (as provided for certain diagnoses) treatments in excess of one per calendar month.
- Electrocardiogram services exceeding twelve per year.
- Manipulations of the spine performed by a chiropractor in excess of two per month.
- Full psychiatric sessions exceeding two per month.
- In-hospital medical services if surgery (other than minor) was performed within 3 days of the submitted in-hospital medical service.
- Multiple surgery (other than minor) performed within 3 days of each other.
- X-ray, pathology, diagnostic medical or consultation services in excess of one per day.
- Surgery (other than minor) if a consultation was performed by the same doctor within 7 days of the submitted surgery, and minor surgery if a consultation was performed by the same doctor on the same day as the submitted minor surgery.
- Consultation occurring within 7 days prior to surgery, assistant surgery, anesthesia or in-hospital medical.
- Home/office visit(s) if another home/office visit was performed on the same day.
- In-hospital medical services if a consultation was performed within 3 days of the submitted in-hospital medical service.
- In-hospital medical services if an in-hospital medical service was performed within 3 days of the submitted in-hospital medical service.
- Anesthesia if anesthesia was performed within 3 days of the submitted anesthesia.
- Durable medical equipment rental claim if a purchase claim was previously paid.
- Durable medical equipment purchase claim if a purchase claim has previously been paid.
- Services relating to renal disease.
- Claims from physicians in Cumberland, Dauphin, Lancaster and York counties that report a primary diagnosis of diabetes, hypertension, benign hyperplasia of prostate, or cataract.

ACP schedules state meetings

The American College of Physicians will sponsor two regional meetings for Pennsylvania physicians designed to bring them up to date on late developments in the field of internal medicine.

A two day scientific meeting, October 31 to November 1, will be held in Morgantown, West Virginia, for the West Virginia/ Western Pennsylvania Region of ACP. An Eastern Pennsylvania Regional Meeting will be held October 31 to November 2 at the Host Farm in Lancaster.

For more information regarding the Western Pennsylvania Regional Meeting contact John E. Jones, M.D., F.A.C.P., ACP's representative in West Virginia, West Virginia University Medical Center, Morgantown, WV 26505. In charge of arrangements for the Eastern Pennsylvania Region is Francis J. Sweeney, Jr., M.D., F.A.C.P., Thomas Jefferson University Hospital, 11th and Walnut Sts., Philadelphia, PA 19107.

Medical Arts '75 programs announced

The Pennsylvania Medical Society will sponsor Medical Arts '75, thirteen scientific and educational programs for continuing medical education. The programs will be held over a three day period, Wednesday, November 5, to Friday, November 7, at the Host Inn, Harrisburg.

Medical Arts '75 will offer medical programs in internal medicine, colon and rectal surgery, allergy, orthopaedics, physical medicine and rehabilitation, and plastic surgery. Programs concerning administrative medicine, Pennsylvania Blue Shield, medical assistants, and medical educators, which may be of interest to administrators, office aides and assistants, and educators, as well as physicians, are also included in the schedule.

Programs are sponsored by various organizations in the state. Among them are: the Pennsylvania Allergy Association; Pennsylvania Society of Internal Medicine; Pennsylvania Society of Colon and Rectal Surgery; Pennsylvania Society, American Association of Medical Assistants, Inc.; Pennsylvania Blue Shield, the Pennsylvania Academy of Physical Medicine and Rehabilitation; the Robert H. Ivy Society; and the Pennsylvania Orthopaedic Society. Many of the sessions will offer Category I credit toward the Physician's Recognition Award of the American Medical Association.

For more information about a particular program, contact the PMS Council on Education and Science, 20 Erford Road, Lemoyne, PA 17043.

Geisinger expansion adds 22 new physicians, two departments

Geisinger Medical Center, Danville, has added 22 new physicians to its staff and opened 2 new departments recently.

The department of cardiac surgery was formed by separating it from cardiovascular and thoracic surgery. Donald Bowes, M.D., a Mayo trained cardiac surgeon, directs the new department. The other newly formed department is general internal medicine.

The 22 new physicians bring the total number of doctors to 117 and are in the following specialties: cardiology; hematology; oncology; emergency medicine; otolaryngology; OB/GYN; surgery; pathology; radiology; pediatrics; mental health; and rehabilitation medicine.

In the past year admissions rose by 3 percent and outpatient visits by 7 percent. Another measure taken to meet increased demands for clinical service, two departments—dentistry and oral surgery and OB/GYN—have begun weekly night clinics.

Geisinger plans more expansion, including the hiring of 22 more physicians and the construction of a new clinic building, x-ray facility, and operating room. Funding for the expansion will be obtained partly through marketing of bonds through a County Hospital Authority now being organized, according to Dr. Henry Hood, executive director.

Special training for Vietnam refugee physicians

The U.S. Department of Health, Education, and Welfare has designed a special program to help Vietnamese refugee physicians to qualify for medical practice in the U.S.

The program is geared to provide educational assistance to the physicians who must pass the Educational Commission for Foreign Medical Graduates (ECFMG) examination in order to enter an approved graduate training program required for state licensure.

Costing about $1.3 million, the program will provide support to institutions for development and implementation of courses, stipends for travel, and subsistence for participating refugees. Funding will be provided under the Indochina Refugee and Migration Assistance Act of 1975.

The program is short term and leaves most aspects of career development to the individual physician. So far, out of almost 300 Vietnamese physicians, 3 have met U.S. licensure requirements and 30 have passed the ECFMG.

Six hospitals join in cancer program

Six eastern Pennsylvania hospitals have joined to participate in a program designed to bring improved care to patients with cancer of the head and neck.

The three year program, which is funded by the National Cancer Institute, now includes: Hahnemann Medical College and Hospital, Pennsylvania Hospital, Lankenau Hospital, and Metropolitan Hospital, all in Philadelphia; Grandview Hospital, Sellersville; and St. Luke's Hospital, Bethlehem.

The purposes are to more closely link the specialties used in treatment of head and neck cancer, to train personnel in early diagnosis, and to examine patients for early signs of malignancy in the head and neck regions.

Board approves Dr. Masland's appointments

The Society Board of Trustees at its August 13 meeting confirmed the appointments, made by David S. Masland, M.D., PMS president elect, to the administrative councils, the Committee on Relationships with Allied Professions, and the Interspecialty Committee for 1975-76. They are as follows:

Council on Education and Science—James A. Raub, M.D., Allegheny County, chairman; David W. Kistler, M.D., Luzerne County, vice chairman; Gerald L. Andriole, M.D., Luzerne County; Mark Berger, M.D., Dauphin County; William E. DeMuth, M.D., Cumberland County; Paul W. Dishart, M.D., Allegheny County; Frederick D. Fister, M.D., Lehigh County; William C. Grasley, M.D., Centre County; Arthur B. Hayes, M.D., Dauphin County; Abram M. Hostetter, M.D., Lebanon County; Roland A. Loeb, M.D., Lancaster County; David G. Moyer, M.D., Montgomery County; Herbert C. Perlman, M.D., Cumberland County; Nathan Sussman, M.D., Dauphin County; Samuel G. Watterson, M.D., Somerset County; Gerhard Werner, M.D., Allegheny County; Theodore L. Yarboro, M.D., Mercer County; Nikitas J. Zervanos, M.D., Lancaster County.

Council on Governmental Relations—Donald E. Harrop, M.D., Chester County, chairman; Michael P. Levis, M.D., Allegheny County, vice chairman; R. William Alexander, M.D., Berks County; Leonard Bachman, M.D., Philadelphia County; Robert J. Carroll, M.D., Allegheny County; Paul A. Cox, M.D., Cumberland County; Herbert Fellerman, M.D., Luzerne County; H. Keith Fischer, M.D., Philadelphia County; Charles A. Heisterkamp, III, M.D., Lancaster County; J. Preston Hoyle, M.D., Union County; Lawrence J. Mellon, Jr., M.D., Delaware County; David I. Thompson, M.D., Cumberland County; Bernard B. Zamostien, M.D., Philadelphia County.

Council on Medical Service—Henry H. Fetterman, M.D., Lehigh County, chairman; J. Joseph Danyo, M.D., York County, vice chairman; Lester A. Dunmire, M.D., Allegheny County; Wayne W. Helmick, M.D., Beaver County; Webb S. Hersperger, M.D., Cumberland County; J. Scott Hommer, M.D., Blair County; John G. Pontius, M.D., Lancaster County; Robert A. Schein, M.D., Allegheny County; John L. Steigerwalt, M.D., Montgomery County; R. Robert Tyson, M.D., Philadelphia County; Charles K. Zug, III, M.D., Northampton County; Joseph N. Demko, M.D., Lackawanna County; John Helwig, Jr., M.D., Philadelphia County.

Council on Professional Relations and Services—Robert Poole, M.D., Chester County, chairman; John C. Cwik, M.D., Cambria County, vice chairman; Ali A. Alley, M.D., Columbia County; Harry D. Bikle, M.D., Franklin County; Stanley N. Cohen, M.D., Philadelphia County; Donald G. Crawford, M.D., Dauphin County; Lawrence D. Ellis, M.D., Allegheny County; David G. Gillium, M.D., Tioga County; Richard L. Huber, M.D., Lackawanna County; Thaddeus Lekawa, M.D., York County; Carol N. Maurer, M.D., Venango County; William A. Shaver, M.D., Lebanon County; Donald G. Urban, M.D., Cumberland County.

Committee on Relationships with Allied Professions—Carmela F. deRivas, M.D., Montgomery County, chairman; Paul L. Shallenberger, M.D., Bradford County; John W. Tull, M.D., York County; Virginia E. Washburn, M.D., Allegheny County; Fred S. Wilson, M.D., Montgomery County.

The Board in addition approved Dr. Masland's appointments to the Interspecialty Committee. The members and their alterantes are:

Allergy—Martin A. Murcek, M.D., Westmoreland County, member; Gilbert A. Friday, M.D., Allegheny County, alternate.

Anesthesiology—Louis J. Hampton, M.D., York County, member; Robert S. Wagner, Jr., M.D., Lancaster County, alternate.

Colon and Rectal Surgery—Howard D. Trimpi, M.D., Lehigh County, member; Indru T. Khubchandani, M.D., Lehigh County, alternate.

Dermatology—Herbert M. Parnes, M.D., Dauphin County, member; Joseph H. Gerdes, Jr., M.D., Dauphin County, alternate.

Family Physicians—Franklin C. Kelton, M.D., Montgomery County, member; Leroy A. Rodgers, M.D., Cambria County, alternate.

Internal Medicine—Vacant

Neurosurgery—Henry L. Hood, M.D., Montour County, member; J. P. Argires, M.D., Lancaster County, alternate.

Obstetrics and Gynecology—Leopold Loewenberg, M.D., Philadelphia County, member; James Bates, M.D., Montour County, alternate.

Ophthalmology—Vacancy; Turgut N. Hamdi, M.D., Philadelphia County, alternate.

Otolaryngology—Eugene B. Rex, M.D., Montgomery County, member; James M. Cole, M.D., Montour County, alternate.

Orthopaedic—Robert H. Cram, M.D., Philadelphia County, member; Willard H. Love, Jr., M.D., Dauphin County, alternate.

Clinical Pathology—Rosario

(Continued on page 32)

Warehouse space, staff acquired

Medical cooperative plans September opening

The Pennsylvania Medical Cooperative is approaching the open for business stage of its growth, and expects to announce the date this month. Besides disposable items, most of which have experienced large price increases during the current inflationary spiral, the cooperative will very soon be able to offer office and surgical equipment as well.

The leasing of a warehouse and hiring of additional personnel have been the subject of recent meetings of the Cooperative Incorporating Board.

Cooperative officers are: H. Robert Davis, M.D., Boiling Springs, president; Robert N. Moyers, M.D., Meadville, vice president; Robert Poole, M.D., West Chester, secretary; John F. Rineman, executive vice president of the State Society, treasurer; and Richard L. Huber, M.D., Scranton, assistant secretary treasurer.

H. ROBERT DAVIS, M.D., president of the Pennsylvania Medical Cooperative, on the right, and Jack Hogan, manager of the cooperative, study the agenda for a recent meeting of the incorporating board.

The State Society's Board of Trustees is represented on the cooperative board by Kenneth L. Cooper, M.D., Williamsport; and George A. Rowland, M.D., Millville. Other members of the incorporating board are: James B. Donaldson, M.D., Philadelphia; Leo C. Eddinger, M.D., Allentown; Lawrence D. Ellis, M.D., Pittsburgh; David F. Gillum, M.D., Wellsboro; Thaddeus Lekawa, M.D., York; and Ulysses E. Watson, M.D., Philadelphia.

Mental health component of early screening program

The National Institute of Mental Health (NIMH) and the Medical Services Administration (MSA) of the Social and Rehabilitation Service will assist states in developing the mental health component of a nationwide health screening program for children and youth.

The two agencies will aid states in the development of guidelines to implement mental health provisions of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, established through a 1967 amendment to Title XIX (medicaid) of the Social Security Act.

EPSDT is a health care screening and intervention program open to medicaid eligible children and youth up to 21 years of age and covers areas of physical and dental health as well as mental health.

The two agencies will direct their efforts toward clarifying the mental health dimensions of developmental assessment. NIMH will evaluate existing screening and diagnostic tools used to identify developmental and mental health problems at various life stages between birth and 21 years.

Board approves appointments

(Continued from page 31)

Maniglia, M.D., Dauphin County, member; John W. Eiman, M.D., Philadelphia County, alternate.

Pediatrics—James E. Jones, M.D., Dauphin County, member; Vacancy.

Physical Medicine and Rehabilitation—John S. Tennant, M.D., Dauphin County, member; Robert C. Steinman, M.D., Lancaster County, alternate.

Plastic Surgery—Thomas J. Nauss, M.D., Dauphin County, member; Harvey W. Austin, M.D., Allegheny County, alternate.

Psychiatry—Rex A. Pittenger, M.D., Allegheny County, member; Edward C. Leonard, Jr., M.D., Philadelphia County, alternate.

Radiology—C. Jules Rominger, M.D., Philadelphia County, member; Ross H. Smith, Jr., M.D., Allegheny County, alternate.

You are cordially invited to attend the Twenty-seventh Annual State Dinner

Tuesday evening—October 7, 1975
Host Farm Resort Motel
Lancaster, Pennsylvania

Reception

(compliments of Frank B. Hall & Co. of Pennsylvania, Inc.)

Dinner

Dancing

Installation of the 126th President
Pennsylvania Medical Society

Presentation of Past President's Medallion
A. Reynolds Crane, M.D., 125th President

Presentation of the Distinguished Service Award
Jonathan E. Rhoads, M.D.

Presentation of State Benjamin Rush Awards

IMPORTANT NOTICE:

The Host Farm Resort Motel operates under the American plan—breakfast and dinner are included in the room charge. Therefore house guests will receive State Dinner tickets subject only to a $3.00 surcharge per person. The surcharge is the result of the menu selected for the State Dinner and will be added to the room charges. Tickets for those not registered at the hotel will be $10.50 per person. Both registered and non-registered persons may pick up their State Dinner tickets during Annual Session at the Society's registration desk which will be located in the Host Farm lobby.

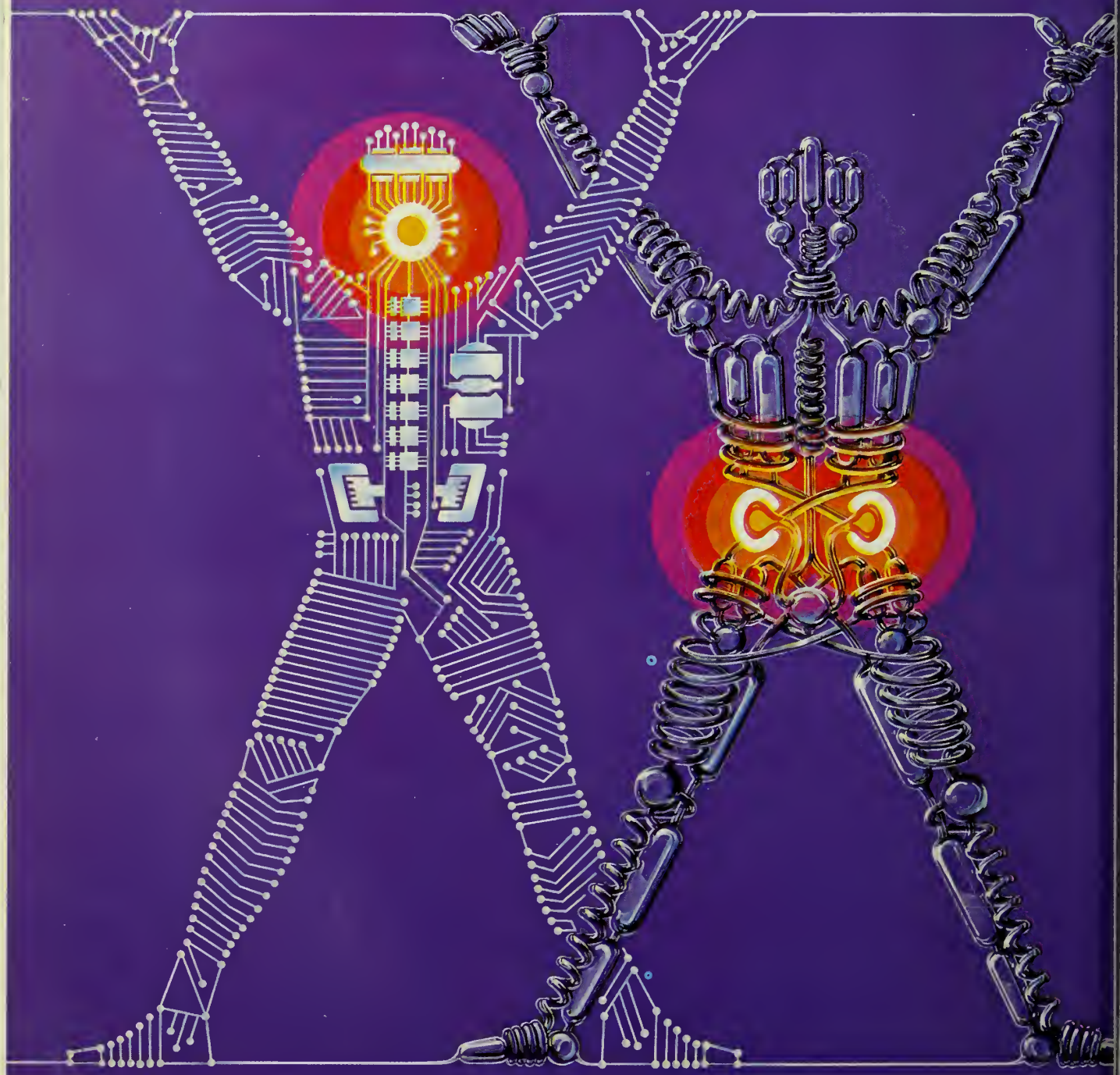
nonreserpine

Combipres®

Each tablet contains:
Catapres®, brand of clonidine hydrochloride,
0.1 or 0.2 mg and chlorthalidone, 15 mg

.1 and .2

The only major new combination antihypertensive in a decade



Please see brief summary of the prescribing information including precautions, warnings, adverse reactions.

nonreserpine

Combipres 1 and 2

Each tablet contains:
Catapres® brand of clonidine hydrochloride, 0.1 or 0.2 mg and chlorthalidone, 15 mg

Works better than either component in equivalent doses*

Works in mild to severe hypertension

Works conveniently for patients who need more than one drug*

Works for less than the cost of separate Rxs*

Works and works and works—convenience and economy promote long-term patient compliance

*Combipres is not indicated for initial therapy of hypertension. It is indicated for hypertensive patients who need more than one drug for adequate lowering of blood pressure and who have proved to be responsive to its components given separately in dosages equivalent to those in the combination.

Warning: This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

Indication: The drug is indicated in the treatment of hypertension (see box warning).

Contraindications: Patients with known hypersensitivity to chlorthalidone and patients with severe renal or hepatic diseases.

Warnings: Tolerance may develop in some instances necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxicity findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefit outweighs the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Combipres in children.

Precautions: When discontinuing Combipres, reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of Combipres therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect of the clonidine hydrochloride component. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other antihypertensive agent, Combipres should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Combipres should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmological findings have been recorded with Catapres, in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Patients predisposed toward or affected by diabetes should be tested periodically while receiving Combipres, because of the hyperglycemic effect of chlorthalidone.

Because of the possibility of progression of renal failure, periodic determination of the BUN is indicated. If, in the physician's opinion, a rising BUN is significant, the drug should be stopped.

The chlorthalidone component of Combipres may lead to sodium and/or potassium depletion. Muscular weakness, muscle cramps, anorexia, nausea, vomiting, constipation, lethargy or mental confusion may occur. Severe dietary salt restriction is not recommended in patients receiving Combipres.

Periodic determinations of the serum potassium level will aid the physician in the detection of hypokalemia. Extra care should be given to detection of hypokalemia in patients receiving adrenal corticosteroids, ACTH or digitalis. Hypochloremic alkalosis often precedes other evidence of severe potassium deficiency. Frequently, therefore, more sensitive indicators than the potassium serum level are the serum bicarbonate and chloride concentrations. Also indicative of potassium depletion can be electrocardiographic alterations such as changes in conduction time, reduction in amplitude of the T wave; ST segment depression; prominent U wave. These abnormalities may appear with potassium depletion before the serum level of potassium decreases. To lessen the possibility of potassium deficiency, the diet, in addition to meat and vegetables, should include potassium-rich foods such as citrus fruits and bananas. If significant potassium depletion should occur during therapy, oral potassium supplements in the form of potassium chloride (3 to 4.5 gm/day), fruit juice and bananas should be given.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy.

Clonidine hydrochloride: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one case of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash; impotence, urinary retention; increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Chlorthalidone: Symptoms such as nausea, gastric irritation, anorexia, constipation and cramping, weakness, dizziness, transient myopia and restlessness are occasionally observed. Headache and impotence or dysuria may occur rarely. Orthostatic hypotension has been reported and may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics. Skin rashes, urticaria and purpura have been reported in a few instances.

A decreased glucose tolerance evidenced by hyperglycemia and glycosuria may develop inconsistently. This condition, usually reversible on discontinuation of therapy, responds to control with antidiabetic treatment. Diabetics and those predisposed should be checked regularly.

As with other diuretic agents hypokalemia may occur (see Precautions). Hyperuricemia may be observed on occasion and acute attacks of gout have been precipitated. In cases where prolonged and significant elevation of blood uric acid concentration is considered potentially deleterious, concomitant use of a uricosuric agent is effective in reversing hyperuricemia without loss of diuretic and/or antihypertensive activity.

Idiosyncratic drug reactions such as aplastic anemia, thrombocytopenia, leukopenia, agranulocytosis, and necrotizing angiitis have occurred, but are rare.

The remote possibility of pancreatitis should be considered when epigastric pain or unexplained gastrointestinal symptoms develop after prolonged administration.

Other adverse reactions which have been reported with this general class of compounds include: jaundice, xanthopsia, paresthesia and photosensitization.

Overdosage: *Catapres (clonidine hydrochloride):* Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals abolishes all effects of Catapres overdosage.

Chlorthalidone: Symptoms of overdosage include nausea, weakness, dizziness, and disturbances of electrolyte balance. There is no specific antidote, but gastric lavage is recommended, followed by supportive treatment. Where necessary, this may include intravenous dextrose and saline with potassium administered with caution.

How Supplied: Combipres® 0.1 (Each tablet contains clonidine hydrochloride 0.1 mg + chlorthalidone 15 mg). It is available as pink, oval, single-scored compressed tablets in bottles of 100.

Combipres® 0.2 (Each tablet contains clonidine hydrochloride 0.2 mg + chlorthalidone 15 mg). It is available as blue, oval, single-scored compressed tablets in bottles of 100.

For complete details, please see full prescribing information.

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Boehringer Ingelheim Ltd.
Elmsford, New York 10523

Blue Shield schedules further assistants' courses

Pennsylvania Blue Shield is sponsoring special office assistants' meetings explaining claims submission procedures. The Society Board of Trustees urge physicians to send their assistants to these meetings. Below is a listing of the scheduled meetings in central Pennsylvania. For a list of meetings in eastern and western Pennsylvania see the August issue of PENNSYLVANIA MEDICINE.

September 10, 9:30 a.m., Mercy Hospital, Scranton
September 10, 10:00 a.m., Good Samaritan Hospital, Pottsville
September 10, 9:00 a.m., Soldiers and Sailors Memorial Hospital, Wellsboro
September 16, 10:00 a.m., Treadway Inn, Lebanon
September 17, 9:00 a.m., Muncy Valley Hospital, Muncy
September 18, 9:00 a.m., Nichols Valley Motor Inn, Clarks Summit
September 23, 10:00 a.m., 7:30 p.m., Nesbitt Hospital, Kingston
September 23, 10:00 a.m., Holiday Inn Towne, Reading
September 24, 10:00 a.m., Allentown Sacred Heart Hospital, Allentown
September 25, 9:30 a.m., Nichols Valley Motor Inn, Clarks Summit
September 29, 7:30 p.m., St. Joseph Hospital, Hazleton
September 30, 9:30 a.m., Belvedere Medical Center, Carlisle
October 1, 10:00 a.m., Scranton Easton Motor Inn, Easton
October 1, 9:30 a.m., Lutheran Home, York
October 1, 10:00 a.m., Motel Inn Towne, Stroudsburg
October 2, 10:00 a.m., Holiday Inn Towne, Reading
October 2, 10:00 a.m., Holiday Inn-East, Rts. 512 and 522, Bethlehem
October 2, 10:00 a.m., Luzerne County Medical Society Building, Wilkes-Barre
October 8, 9:30 a.m., Polyclinic Hospital, Harrisburg
October 8, 10:00 a.m., Walck's Restaurant, Lehighton
October 8, 9:00 a.m., Sheraton Motor Inn, Williamsport
October 9, 9:30 a.m., Capitol Motel Restaurant, Harrisburg
October 15, 10:00 a.m., Nesbitt Memorial Hospital, Kingston
October 16, 9:30 a.m., Osteopathic Hospital, York
October 21, 9:30 a.m., Holiday Inn, Chambersburg
October 22, 9:30 a.m., Hanover Hospital, Hanover
October 23, 9:30 a.m., Waynesboro Hospital, Waynesboro
October 28, 9:30 a.m., Holiday Inn, Chambersburg
October 30, 9:30 a.m., Annie Warner Hospital, Gettysburg
November 14, 9:30 a.m., 2:00 p.m., Blue Shield Building-West, Camp Hill

Consortium names goals

The Milton S. Hershey Medical Center's department of family and community medicine has established the Pennsylvania Family Practice Residency Consortium.

The consortium now includes seven state hospitals as charter participants. They are: Altoona Hospital; Conemaugh Valley Hospital, Johnstown; Geisinger Medical Center, Danville; Monsour Hospital and Clinic, Jeanette; Shadyside Hospital, Pittsburgh; St. Joseph's Hospital, Reading; and Hershey Medical Center.

Goals of the consortium are to improve training programs in family medicine and to provide more opportunities in order to increase the number of family physicians in Pennsylvania.

There are three categories of membership in the consortium. "Participants" are charter member hospitals that have accredited family medicine residency programs. Hospitals in an active stage of development of programs are "associate participants" and "allied participants" are not active but wish to attend meetings and take part in certain activities. York Hospital and Sacred Heart Hospital in Allentown are allied participants.

Thomas L. Leaman, M.D., professor and chairman of the department of family and community medicine at Hershey, is the program's coordinator. George A. Rowland, M.D., Trustee and Councilor of the Fourth District, member of the Pennsylvania Delegation to the AMA, and vice president of the American Academy of Family Physicians, is a consultant and field coordinator.

ACS appoints Mahaffey

The American Cancer Society recently appointed Thomas E. Mahaffey as executive vice president of the Pennsylvania Division. He succeeds John Halloran, who is retiring.

Mahaffey had served as executive director of the Cancer Society's Chicago Division since 1963 and has been with the society since 1954. In this new post, he will direct the operations of 61 county units and more than 115,000 workers.

House ordered poll results revealed

Among the actions taken by the House of Delegates at its special session on the malpractice crisis was to conduct a poll of Society members whose professional liability coverage is with Argonaut Insurance Co. As of August 20, 1975 responses received to questions are as they appear below.

1. What is your professional liability rating classification?

TERRITORY I		*TERRITORY II*		*NO TERRITORY LISTED*		*GRAND TOTALS*	
Class I	266	Class I	390	Class I	3	TERRITORY I	657
Class II	37	Class II	73	Class II	0	TERRITORY II	862
Class III	39	Class III	89	Class III	0	UNSPECIFIED	5
Class IV	116	Class IV	142	Class IV	0		1524
Class V	199	Class V	168	Class V	2		
TOTAL	657	TOTAL	862	TOTAL	5		

2. Do you feel the premium you pay for professional liability insurance is commensurate with the financial protection it affords you?

TERRITORY I

	Yes	*No*	*No Comment*
Class I	133	119	14
Class II	13	24	0
Class III	10	27	2
Class IV	14	99	3
Class V	27	167	5
TOTAL	197	436	24

TERRITORY II

	Yes	*No*	*No Comment*
Class I	228	145	17
Class II	29	42	2
Class III	29	54	6
Class IV	33	103	6
Class V	54	112	2
TOTAL	373	456	33

NO TERRITORY LISTED

	Yes	*No*	*No Comment*
Class I	2	1	0
Class II	0	0	0
Class III	0	0	0
Class IV	0	0	0
Class V	0	2	0
TOTAL	2	3	0

GRAND TOTALS

	Yes	*No*	*No Comment*
TERRITORY I	197	436	24
TERRITORY II	373	456	33
UNSPECIFIED	2	3	0
	572	895	57

3. Would you urge the Pennsylvania Medical Society to bring legal action against Argonaut to effect a roll back of premiums, even if such action entailed the risk that Argonaut might leave the State of Pennsylvania?

TERRITORY I

	Yes	*No*	*No Comment*
Class I	57	204	5
Class II	15	21	1
Class III	9	29	1
Class IV	58	57	1
Class V	125	70	4
TOTAL	264	381	12

TERRITORY II

	Yes	*No*	*No Comment*
Class I	57	325	8
Class II	13	59	1
Class III	21	67	1
Class IV	50	91	1
Class V	55	110	3
TOTAL	196	652	14

NO TERRITORY LISTED

	Yes	*No*	*No Comment*
Class I	2	1	0
Class II	0	0	0
Class III	0	0	0
Class IV	0	0	0
Class V	2	0	0
TOTAL	4	1	0

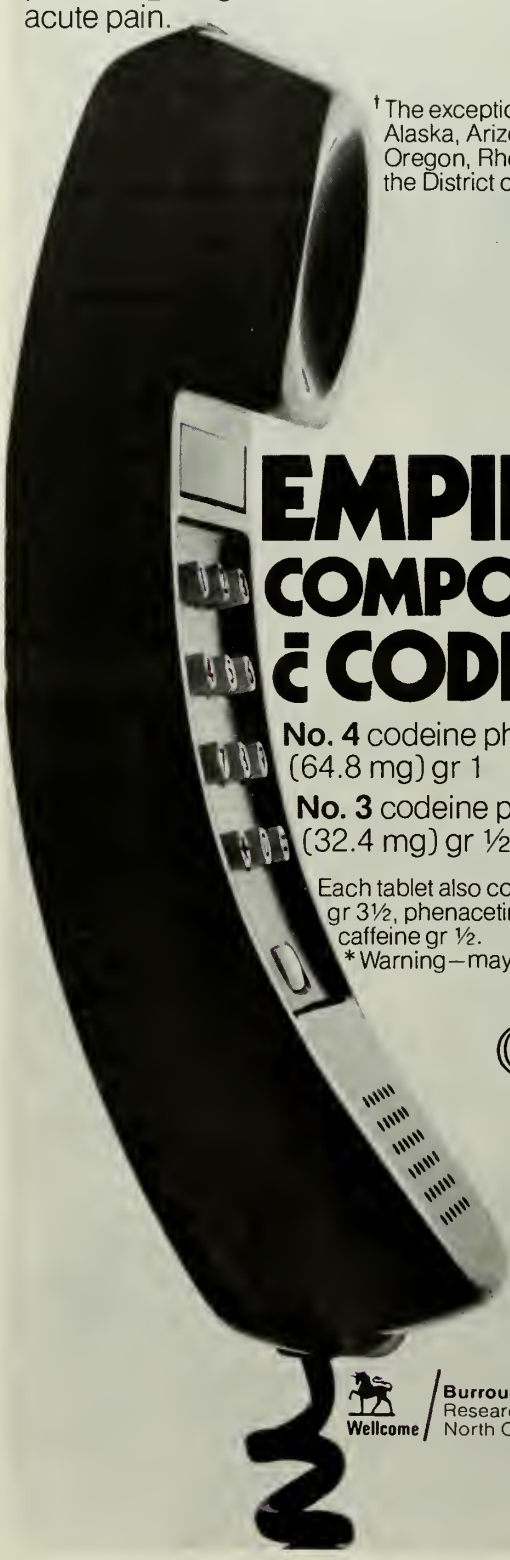
GRAND TOTALS

	Yes	*No*	*No Comment*
TERRITORY I	264	381	12
TERRITORY II	196	652	14
UNSPECIFIED	4	1	0
TOTALS	464	1034	26

The Pain Phone

When a telephone prescription for pain relief is necessary or convenient, you can call in your order for Empirin Compound with Codeine in 45 of the 50 states† That includes No. 4, which provides a full grain of codeine for more intense, acute pain.

† The exceptions: Alaska, Arizona, Maine, Oregon, Rhode Island, and the District of Columbia.



EMPIRIN® COMPOUND WITH CODEINE

No. 4 codeine phosphate* (64.8 mg) gr 1

No. 3 codeine phosphate* (32.4 mg) gr ½

Each tablet also contains aspirin gr 3½, phenacetin gr 2½, caffeine gr ½.

*Warning—may be habit-forming.

C III

Wellcome | **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

Pro-Banthine®

brand of propantheline bromide

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to: G. D. Searle & Co.
Medical Department, Box 5110, Chicago, Ill. 60680 481

"Antiacid" action for ulcer patients...

one of the many things you need in an anticholinergic.

Pro-Banthine is considered adjunctive in total peptic ulcer therapy that may include diet, conventional antacids, bed rest, and other supportive measures.

Pro-Banthine is provided in several different dosage forms which will meet virtually any clinical need. It is just as versatile in filling patient needs, among which are:

"Antiacid" action—Pro-Banthine® (propantheline bromide) reduces gastric secretory volume and resting total and free acid.

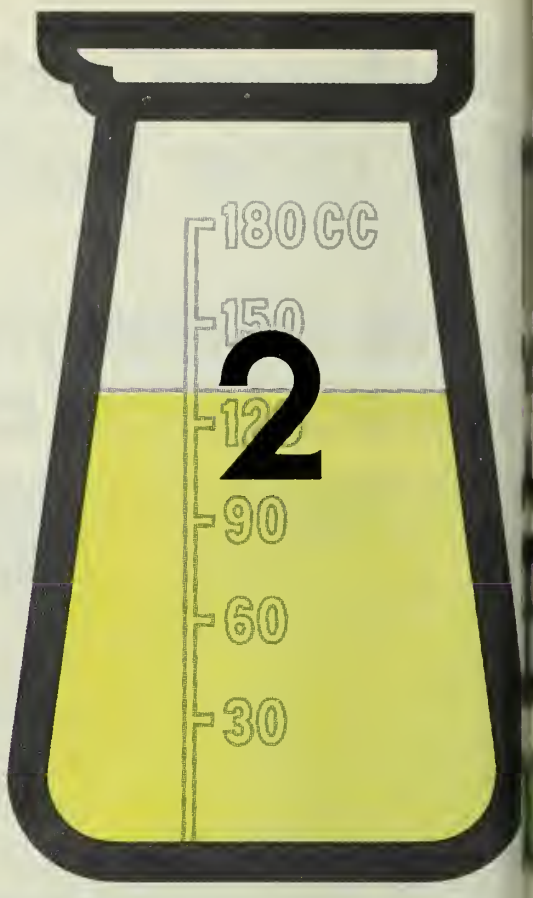
"Analgesic" action—Pro-Banthine helps to control the acid-spasm-pain complex.

Vigorous anticholinergic action—Pro-Banthine® Vials, 30 mg., are for intramuscular or intravenous use when prompt and vigorous anticholinergic action is required.

Mild anticholinergic action—Pro-Banthine® Half Strength, 7.5 mg. tablets, for more exact adjustment of maintenance dosage in mild to moderate gastrointestinal disorders.

Pro-Banthine®
(propantheline bromide)

a good option in peptic ulcer



Adequate fluid intake

Frequent voiding

The 3rd Basic

Gantanol®
(sulfamethoxazole)
B.I.D.

ur tablets (0.5 Gm each) STAT-
n 2 tablets B.I.D. for 10-14 days

sic therapy with
nvenience for
ute nonobstructed
stitis

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic non-obstructed urinary tract infections (primarily pyelonephritis, pyelitis, and cystitis) due to susceptible organisms. ***Note:* Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials, including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

- **Effective against susceptible E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis and, less frequently, Proteus vulgaris**

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

makes sense

For long-term control of hypertension

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* WARNING

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemi and gout, reversible nitrogen retention, decreasin alkali reserve with possible metabolic acidosis, hype glycemia and glycosuria (diabetic insulin requir ments may be altered), digitalis intoxication (i hypokalemia). Use cautiously in surgical patient Concomitant use with antihypertensive agents ma result in an additive hypotensive effect. 'Dyazid interferes with fluorescent measurement c quinidine.

Adverse Reactions: Muscle cramps, weakness, di ziness, headache, dry mouth; anaphylaxis; rasl urticaria, photosensitivity, purpura, other derm tological conditions; nausea and vomiting (may ir dicate electrolyte imbalance), diarrhea, constipatio other gastrointestinal disturbances. Necrotizin vasculitis, paresthesias, icterus, pancreatitis xanthopsia and, rarely, allergic pneumonitis hav occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Un Packages of 100 (intended for institutional use only

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

'DYAZIDE'

Just once or twice daily for maintenance. Hydrochlorothiazide to help keep blood pressure down and triamterene to help keep potassium levels up.

Give America a Bicentennial Birthday Present

American physicians are cordially invited to join the effort to preserve the birthplace of Dr. Benjamin Rush, Signer of the Declaration of Independence and the "Father of American Medicine" as a gift to the Nation on its two hundredth anniversary.

The Benjamin Rush House, Philadelphia, Pennsylvania

Revolutionary patriot, physician, and social activist, Rush was born in this modest farmhouse, which will be preserved in Philadelphia as a symbol of ideals and goals for which we strive today. This living landmark will serve as a community meeting center and an education and inspirational monument for future generations.

We need $150,000. To date the American Psychiatric Association has raised $25,000. School children, women's clubs, and patriotic citizens have contributed $20,000 to the "doctors' project." Now Pennsylvania's Medical Society invites you to share in preserving this historic medical treasure as your Bicentennial gift.

A. Reynolds Crane, M.D., President
Pennsylvania Medical Society

Honorary Patrons

The Honorable Milton J. Shapp, *Governor*
Commonwealth of Pennsylvania

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My birthday gift is enclosed

Name: _____

Address: _____

Amount: _____

Mail to: Pennsylvania Medical Society
20 Erford Rd.
Lemoyne, Pa. 17043

When serum cholesterol demands attention...

patients may need...

- Diet control
- A proven cholesterol-lowering adjunct to diet*
- Convenient once-a-day dosage*
- Reasonable cost*

*Choloxin®
(sodium dextrothyroxine)

An agent for low density lipoproteins, "type II hyperlipidemia," in euthyroid, non-cardiac patients.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

See reverse side for full prescribing information

Choloxin® (sodium dextrothyroxine)

The Lipid-Lowering Agent with Once-A-Day Dosage

Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules
See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following:
Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

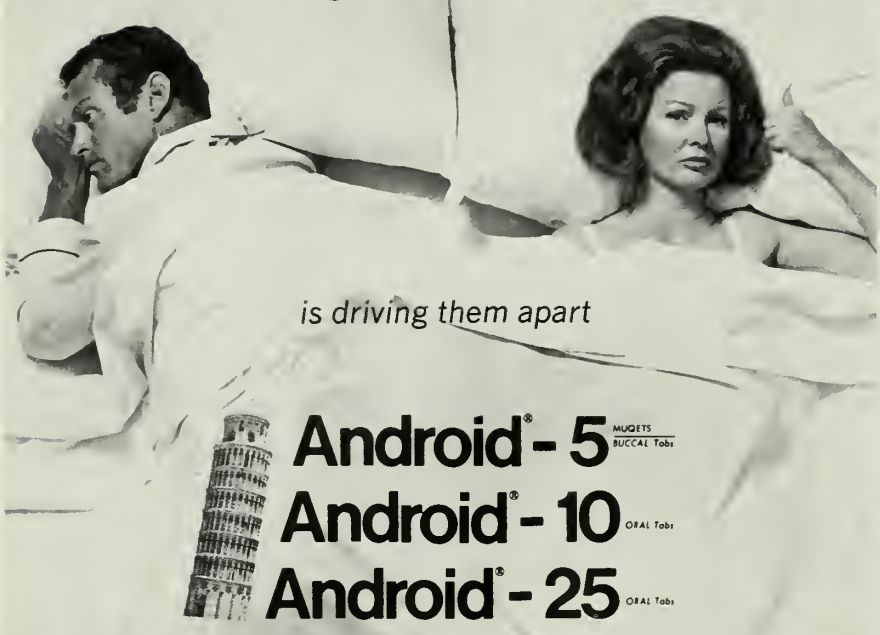
If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES INC
Deerfield, Illinois 60015

When **impotence** *due to*

androgenic deficiency



is driving them apart

Android®-5 MUGETS BUCCAL Tabs

Android®-10 ORAL Tabs

Android®-25 ORAL Tabs

Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg
Riboflavin	2.5 mg
Ascorbic Acid	25.0 mg
Folic Acid	0.1 mg
Vitamin B-12	1.5 mcg
Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide	0.075 mg
Calcium (from Dicalcium Phosphate	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 mg
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg

ACTION AND USES — DOSAGE: 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets. Rx only.

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FAMILY PRACTICE REVIEW

September 29—October 3, 1975

The Milton S. Hershey Medical Center

PURPOSE:
The Department of Family and Community Medicine of The Milton S. Hershey Medical Center has organized a review course in family practice principles to enable family physicians to prepare for board certification or recertification. It is also directed toward improving your potential for providing health services to your patients.

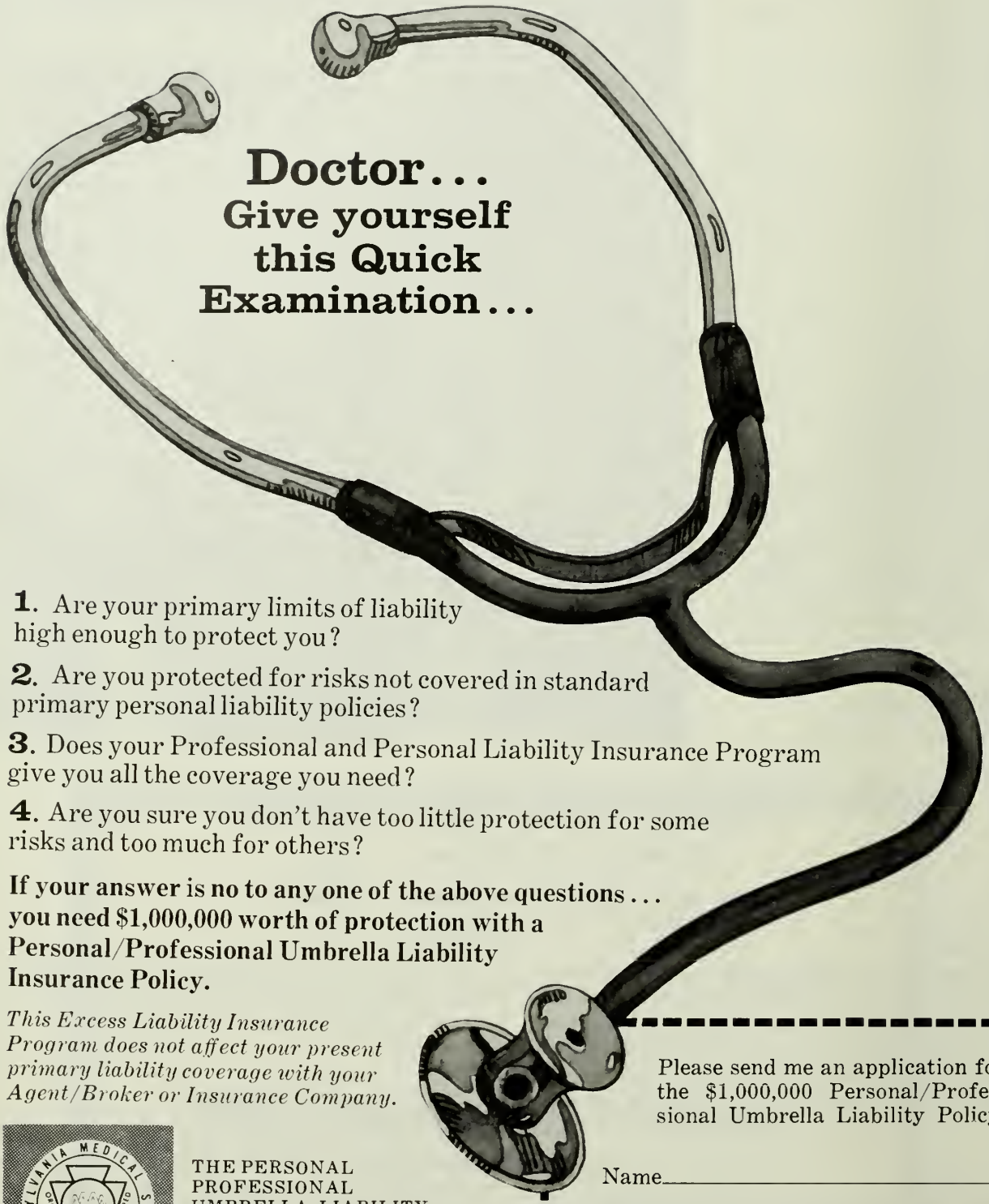
LOCATION:
This course will be conducted in Lecture Room C-Fifth Floor of The Milton S. Hershey Medical Center, The Pennsylvania State University, Hershey, Pennsylvania.

FEE:
The fee for this course is $225 which includes all luncheons, coffee breaks, banquet, and instructional materials.

CREDIT:
This program is acceptable for 48 hours of Category I Credit toward the American Medical Association Physician's Recognition Award.

REGISTRATION INFORMATION:
Contact the Continuing Medical Education office of The Milton S. Hershey Medical Center, The Pennsylvania State University, Hershey, Pennsylvania, 17033. Phone: (717) 534-8898.

It is essential to the planning of this course that advance registrations be returned at the earliest possible date. Registrations will be accepted up to September 24, 1975. No cancellations can be accepted. However, substitutions will be considered through the first day of the course.



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MDs in the news

Michael L. Nahrwold, M.D., was recently appointed assistant of anesthesiology and research associate in physiology in The Pennsylvania State University College of Medicine at The Milton S. Hershey Medical Center. He was previously a clinical associate in the anesthesia department and a researcher in the laboratory of neurochemistry at the National Institute of Neurological Diseases and Stroke.

Ronald E. Cohn, M.D., medical director of Frankford Hospital, Philadelphia, addressed the North Carolina Hospital Association recently on the topic of "The Board/Administration/Medical Staff Interface." He also spoke on "The Role of the Medical Director in the Community Hospital" at the Hospital Medical Conference at Lake Geneva, Wisconsin.

Dorothea D. Glass, M.D., medical director of Moss Rehabilitation Hospital, recently received the 1975 citation of the Commonwealth Board of the Medical College of Pennsylvania. The citation is presented each year to a graduate of the Medical College who is practicing in the state and has made a significant contribution to the medical world. Dr. Glass is also professor of rehabilitation medicine and director of residency training at Temple University School of Medicine and chairman of the department of rehabilitation at Albert Einstein Medical Center.

Paul G. Bovard, M.D., Tarentum, was recently awarded an honorary doctor of science degree by Washington and Jefferson College. Dr. Bovard, a radiologist, was honored for his work as a teacher and his study of silicosis and bone density due to fluoride absorption.

John J. Mikuta, M.D., was elected president of the Obstetrical Society of Philadelphia recently. He is director of gynecologic oncology at the Hospital of the University of Pennsylvania, Woman's Hospital Division, and professor in the university's school of medicine. Dr. Mikuta recently became chairman of the national task force on gynecologic cancer of the American College of Obstetricians and Gynecologists.

Mark M. Mishkin, M.D., recently became president elect of the Association of University Radiologists at the annual meeting in San Diego. He is chief of neuroradiology at the Hospital of the University of Pennsylvania and professor in the school of medicine.

The University of Pennsylvania recently honored **Hugh M. Crumay, M.D.**, for over a quarter of a century of service as a consultant and teacher in its department of dermatology. Dr. Crumay is a dermatologist on the Harrisburg Hospital emeritus staff. He is past president of the Pennsylvania Academy of Dermatology and the Philadelphia Dermatological Society and is currently a member of the Advisory Committee to the National Program for Dermatology.

Two members of the Joseph Stokes Research Institute of The Children's Hospital of Philadelphia recently received grants for research programs. **Mary C. Glick, M.D.**, was awarded a grant for research in cancer, cystic fibrosis, and mental retardation by the National Institutes of Health. **David Pleasure, M.D.**, has received: the neuromuscular program project grant for 1975-78; the mental retardation program grant for 1975-80; the Muscular Dystrophy Clinical Center grant for 1974-77; and the National Foundation March of Dimes grant for 1974-76. **Marshal Nirenberg, M.D.**, chief at the Laboratory of Biochemical Genetics, National Institues of Health, recently presented the Joseph Stokes Memorial Lecture at Children's Hospital. The topic was "The Differentiation of Neuroblastoma Cells."

George J. Thomas, M.D., was recently awarded the Ralph M. Waters International Award for 1974 for his contributions to the field of anesthesiology. Formerly chairman of anesthesiology and professor of surgery at the University of Pittsburgh, Dr. Thomas is presently emeritus professor of surgery.

June F. Klinghoffer, M.D., was named an Outstanding Educator of America recently. Dr. Klinghoffer is professor of medicine at The Medical College of Pennsylvania. In the past she has received the Lindback Award for Distinguished Teaching and the Commonwealth Board award.

DR. KLINGHOFFER

DR. PRATT

Lindsay L. Pratt, M.D., was recently appointed professor of otolaryngology and chairman of the department at Jefferson Medical College. He was formerly associate professor of otolaryngology at the Washington University School of Medicine, St. Louis.

Baruch S. Blumberg, M.D., was chosen to receive the Annual Award of the Gairdner Foundation for his work with the hepatitis B virus. The award will be presented at a dinner in Toronto in October.

The Department of Health, Education, and Welfare recently awarded **Paul K. Schick, M.D., F.A.C.P.**, $96,000 to pursue an investigation of the role of blood platelets in thrombosis. Dr. Schick is assistant professor of medicine at the Medical College of Pennsylvania.

Albert B. Ferguson, Jr., M.D., was chosen recently by the National Institutes of Health to serve as a member of the Institute of Arthritis, Metabolism and Digestive Disease Advisory Council. Dr. Ferguson is professor and chairman of the department of orthopedic surgery at the University of Pittsburgh School of Medicine.

Harris R. Clearfield, M.D., was recently appointed professor of medicine at Hahnemann Medical College and Hospital. He is also director of the division of gastroenterology.

Officers of the Pennsylvania Society of Colon and Rectal Surgery for 1975-76 are: **Josiah C. McCracken, M.D.**, president; **Indru T. Khubchandani, M.D.**, president elect; **Henry Bourland, M.D.**, vice president; **James A. Sheets, M.D.**, secretary; **W. Davy Smith, M.D.**, treasurer.

A scientific exhibit entitled "Beta Blockers in the Management of Angina and Arrhythmias," prepared by **Eugene Coodley, M.D., Stuart Snyder, M.D.,** and **Krishan Bharadwaja, M.D.**, was awarded the gold medal Billings first prize at the annual meeting of the American Medical Association in Atlantic City recently. Dr. Coodley is professor and associate chariman in the department of medicine at Hahnemann Medical College and Hospital.

Ronald Glaser, M.D., has been involved in the Franco-American Scientific Exchange Program which is cosponsored by the Fogarty International Center, National Institutes of Health, and the Institut National de la Sante et de la Recherche Medicale. During the summer Dr. Glaser has been studying the role of the Epstein-Barr virus in the development of naso-pharyngeal tumors.

Zvi Friedman, M.D., has been appointed assistant professor of pediatrics in The Pennsylvania State University College of Medicine at The Milton S. Hershey Medical Center. He was previously a fellow in clinical research in neonatology at Vanderbilt University Medical Center.

Domingo T. Alvear, M.D., attending pediatric surgeon at Polyclinic and Harrisburg Hospitals, was recently certified in pediatric surgery by the American Board of Surgery. He is one of the first physicians to qualify in this special competency.

Richard M. Bergland, M.D., assistant dean for continuing education at The Milton S. Hershey Medical Center, has been appointed representative from the Association of American Medical Colleges to a newly formed Liaison Committee on Continuing Medical Education. The committee is composed of 20 representatives of the AMA, the AAMC, the American Board of Medical Specialties, Council of Medical Specialty Societies, American Hospital Association, Association for Hospital Medical Education, and Federation of State Medical Boards, as well as a public member and a federal member. The committee will develop new principles and policies for continuing medical education and be responsible for supervision and accreditation of these programs nationwide.

Robert E. Shoemaker, M.D., Allentown, recently completed 21 years as secretary for instruction of the Pennsylvania Academy of Ophthalmology and Otolaryngology and was named chairman of its committee on scientific work, succeeding Dr. Paul Craig of Reading. Dr. Shoemaker is a past president of the academy and a recipient of its distinguished Service Award.

Leroy A. Rodgers, M.D., recently became president elect of the Pennsylvania Academy of Family Physicians. Dr. Rodgers is director of ambulatory care and community medicine at Memorial Hospital, Johnstown, and medical director of the Cambria County Child Development Center in Ebensburg.

Edward G. Lakatta, M.D., was recently appointed an Eli Lilly fellow in medical science of the American College of Physicians for 1975. He will spend a year at the Cardiothoracic Institute, London, in the departments of physiology and cardiac medicine.

Simon Skole, M.D., New Castle, was honored recently for 50 years in the practice of medicine. Dr. Skole has practiced in Lawrence County longer than any other pediatrician there. Dr. Skole is recognized by *Who's Who in the East* and has held offices in the Lawrence County Medical Society.

Two physicians from The Medical College of Pennsylvania presented papers at the recent Seventh International Thyroid Conference in Boston. **Mary B. Dratman, M.D.**, presented a paper on "Iodothyronine Metabolism and Catecholamine Enzymes: Effect of Alpha Methyl Para Tyrosine in Thyroidectomized Euthyroid Rats." **Bernard A. Eskin, M.D.**, spoke on the "Blockade of Breast Iodine by Perchlorate."

Anton M. Miller, M.D., received a certificate from Hahnemann Medical College and Hospital in recognition of 50 years of service to the medical profession.

E. L. McCarthy, M.D., Canonsburg, and **Philip Vaccaro, M.D.**, Monongahela, both of Washington County, recently received awards in recognition of 50 years of service to medicine. Both are past presidents of the county medical society and Dr. McCarthy is former medical director of Canonsburg General Hospital.

Harry Little, M.D., recently became an associate in the department of psychiatry and director of inpatient services and consultation in the division of mental health at Geisinger Medical Center, Danville. Dr. Little is former medical director of Mercy Hospital in Urbana, Illinois, and consultant to the psychology department at the University of Illinois.

Three Pennsylvania physicians received the degree of fellowship from the American College of Nuclear Medicine at the organization's recent meeting in Orlando, Florida. **Robert L. Bell, M.D.**, Downingtown; **Louise S. Sherman, M.D.**, Pittsburgh; and **Harry J. Manning, M.D.**, Meadville, were honored for outstanding accomplishments.

Linton A. Whitaker, M.D., was recently a participant in the International Plastic Surgery meeting in Paris. He spoke on the clinical evaluation of cranofacial surgery and the evaluation of membranous bone replacement materials. Dr. Whitaker is assistant surgeon at the Facial Reconstruction Center, Children's Hospital of Philadelphia.

Two Physicians were honored recently by the Bradford County Medical Society. **Henry Rentschler, M.D.**, Athens, and **John Kielty, M.D.**, Towanda, received awards for 50 years of medical service at a dinner in their honor.

Kermit R. Tantum, M.D.., was named director of intensive care units at the Milton S. Hershey Medical Center recently. He is associate professor of anesthesiology and director of intensive respiratory care.

Donald P. Lookingbill, M.D., York, was appointed professor of medicine in the Pennsylvania State University College of Medicine and staff dermatologist at The Milton S. Hershey Medical Center.

Teruo Matsumoto, M.D., Narberth, was named chairman of the department of surgery at Hahnemann Medical College and Hospital recently.

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editorials

Service or learning — or both

The rise in recent years of house staff organizations has been predicated upon the assumption that a distinction can be made between service and education. Since medicine is traditionally a service oriented profession and requires of its practitioners considerable education, it immediately becomes clear that the two are related. The question arises whether they are interdependent and unable to be considered separately or whether they are mutually exclusive and able to be considered as individual entities with respect to the house staffer's practice of medicine.

Several groups, notably the Committee of Interns and Residents in New York City, have successfully defined to the National Labor Relations Board the difference between student and employee and have earned the right to become a collective bargaining agent. They have maintained that the house officer provides service to patients for which the hospital receives third-party remuneration and further that the house officer spends a relatively small percentage of his time in educational activities. On the other hand, the American Association of Medical Colleges espouses the view that interns and residents are students practicing medicine in a controlled environment, under supervision, and that house officers as such are not an integral part of the work force, therefore, not employees.

Set aside for the moment the emotionally charged issue of medical unionism and focus upon the education and/or service premise. Common sense tells us that we learn by doing. Even the simple act of tying one's shoe laces required several hours of practice and weeks or perhaps months depending upon the individual to become proficient. A parallel might be drawn to the medical student who is attempting to tie his first surgical knot. With supervision and by observation, the student receives a practical education in the art of medicine. Likewise, when an intern or resident performs his first bone marrow biopsy or sets his first fracture under the supervision of an attending physician, he is acquiring a skill necessary to function effectively in the role he has chosen.

But when do the activities of the physician-in-training cease to be practical educational experiences and commence to be services to patients? After the tenth bone marrow, or the fiftieth fracture setting? Service begins with the first experience, as inept and unskilled as it might be. If the student were not present, the practicing physician would perform the procedures and so provide the service. From the medical apprenticeship of the 1700s to the residency programs of today, the primary purpose has been to provide a setting in which the student can perform services to improve his skill and education. One cannot help but agree with Sir William Osler's observation that "to study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all." For any graduate program to provide a complete medical education, a proper balance of service for learning must be achieved. This balance is difficult to create and maintain because of the subjective influences in the learning processes.

Students enter into the study of medicine knowing that the ultimate goal is service to patients, the community and society. Hospitals and universities maintain training programs to prepare medical students for the practice of medicine and the delivery of medical care services. Undoubtedly, a house staff contributes positively to the quality of patient care in any community. Whether union organizers can make this same claim remains to be seen.

David A. Smith, M.D.
Medical Editor

Hey, man, give us a break!

Reprinted from *Lackawanna Medicine*

It has unfortunately become increasingly fashionable for some physicians not to accept people on welfare and medicaid as patients. Some physicians wear this badge of exclusion as if it were the Distinguished Service Cross, and are quite proud that they are so busy that "they don't have to see these patients."

Another group has taken a different route: this group will see these economically disadvantaged people on a strictly usual and customary fee for service basis and some will not even give these patients a prescription on a DPA form.

Well, doctor, I personally find both these routes equally reprehensible, reprehensible not only from a humanitarian point of view, but also from a colleague's point of view. You see, doctor, we are all very busy; we all have more patients than we can handle. But you, by not pulling your share of the

load, are adding an unbearable burden on your colleagues and supposed friends. The poor are always with us, and if each of us does his fair share then the task is made at least accomplishable.

How a physician can rationalize his charging a fee to someone on public assistance, the lowest rung of the economic ladder, who is fortunate if he has enough money to pay for the humblest of food, shelter, and clothing, is beyond my comprehension. How a physician can exempt himself from joining with his colleagues in the care of the poor and the economically disadvantaged, and thus effectively adding to the already staggering load of these humane physicians I find unconscionable.

Joseph N. Demko, M.D.
Dunmore

This year's battle

The time, interest, and active work that has been accomplished in the first seven months of 1975 on legislative material, both federal and state, has developed a measure of expertise within the staff and the physicians of the Pennsylvania Medical Society.

This provocative and meaningful education should not be lost or stopped now. Everyone who has put in active time within the physician ranks should be applauded and commended. Certainly, A. Reynolds Crane, M.D., should be singled out for his untiring and persistent efforts in the medical liability crisis.

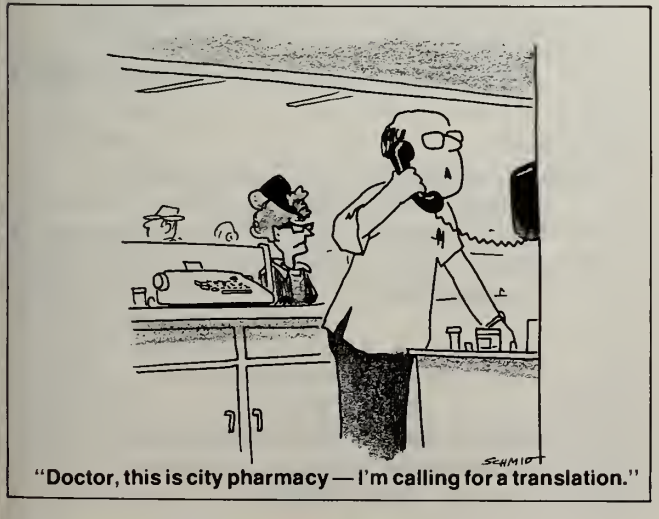
Lines of communication have been established beyond belief. We should not lose the ones we have but should enrich those we have and develop others as needed.

The ad hoc committee should be made permanent in the Council on Governmental Relations. We should begin to write our own legislation. We should begin to ask for the things we want which are germane to medicine and its practice.

The physicians of this country have historically been against legislative moves and rarely present their own legislation. It has been pointed out that the labor leaders appear in Washington every year with legislative requests in a typified "laundry list" as long as your arm. They actively negotiate for all they can get. At the end of the year they thank everyone, go home, and return the next year with a similar and revised "laundry list."

We have excelled this year in our legislative efforts. All who work so diligently should be told appreciatively. However, no matter what we get, we should be ready for the battle next year with our own list just as long and parochial for medicine. Yet, at present, we would do well to thank the legislators for what they are doing, remind them that we have other thoughts, and that we will return for the next session with other legislative requests.

John L. Steigerwalt, M.D.
Guest Editor
Rosemont



"Doctor, this is city pharmacy — I'm calling for a translation."

Reflections on involvement

Reprinted from *The Bulletin* of the Montgomery County Medical Society

Some time ago I heard a story of a young woman in New England who had been raped and tossed half nude into the snow. Knocking on doors, she was unable to get people to call the police for a long time. I speculated that she would have been more quickly successful had she begun breaking windows. It was at that time that I coined one of my favorite phrases:

ADVERSITY IS THE GENESIS OF INVOLVEMENT

The American physician, one of society's most independent personalities, who constantly becomes involved in the adversities of others, has not yet perceived the quicksand in which his own professional feet are standing. It is indeed a curious phenomenon to observe the detachment of our colleagues, many of whom express the feeling that each of us who care enough to be involved (volunteering many hours) do not do enough to deserve their support.

One outstanding British doctor has predicted that we Americans, like the Britons, will not perceive our growing adversity until it is too late.

The current crisis in medical malpractice insurance has indeed stirred more doctors to get involved than at any previous time in recent history. I can only hope that these doctors will not forget the experience when it is over. I believe that the growth of certain untoward trends in our society commands a unity of purpose, and a definite commitment, to defend the right of physicians to practice reasonable and high quality medicine. Some trends of which I speak:

1. During the past ten years the medical record has become a standard instrument for the documentation of physicians' accountability.

2. Medicare standards have become so unreasonable as to compel the AMA to file suit in a certain instance.

3. Medical malpractice judgments against physicians have become totally unreasonable, and the obtaining of malpractice insurance often a very difficult matter.

4. Control of hospital costs, admittedly an admirable objective, brings forth legislation giving the state dictatorial and often brutal power over the administration of voluntary non-profit hospitals.

One has only to look briefly at most government-operated hospitals to recognize their deficiencies in administration. The same answer may be provided by asking any government official which hospital he prefers to be in when it is his own life at risk. The private hospital usually wins.

5. Specific laboratory tests are being prohibited by the Pennsylvania Department of Health, tests that some physicians believe they need with which to anchor their treatment.

6. Health planning (certificate-of-need) legislation has only to include the physician's office as a health care facility to forbid the opening of new offices in urban "cluster" areas.

7. Generic drug dispensing legislation is being sought. We can only hope that it will include measures to protect the patient against low quality drugs.

8. In California, legislation has been passed prohibiting the use of electro-convulsive therapy except as a last resort. ECP is still widely recognized professionally as one of the choice treatments of psychotic depressive disease.

These events tell partially of the times in which we live and of our society's changed attitude toward the physician.

Physician protest is frequently dismissed as the product of selfish, recalcitrant men, their interest in their patients blatantly unrecognized by the planners.

I should like to urge all physicians who ask, "What can I do for Medicine?" to attend more meetings of their medical societies, to actively seek to influence their legislators and to come to the aid of medicine in every reasonable way open to them.

Your involvement with your societies is certain to enhance your individual effectiveness.

Your Adversity is now!

Ulysses E. Watson, M.D.
Philadelphia

Third Annual
Friends Hospital Clinical Conference

EMOTIONS AND ILLNESS: CURRENT VIEWS OF PSYCHOSOMATIC DISEASE

OCTOBER 9 and 10, 1975

FRIENDS HOSPITAL, PHILADELPHIA, PENNSYLVANIA

Presented by Friends Hospital in cooperation with the Department of Mental Health Sciences of Hahnemann Medical College and Hospital

Thursday, October 9

Morning

"Changing Theoretical Concepts in Psychosomatic Medicine"—Morton F. Reiser, M.D.

"Historical Family Systems Approach to Coronary Heart Disease and Cancer"—Claus B. Bahnson, Ph.D.

"Type A Behavior"—Ray H. Rosenman, M.D.

Afternoon

"Cardiovascular Disease: Psychologic Aspects"—Panel Discussion
Howard P. Rome, M.D., Chairman (Morton F. Reiser, M.D., Claus B. Bahnson, Ph.D., Ray H. Rosenman, M.D.)

Evening

Dinner Address—"Stress and Psychosomatic Medicine"—Hans Selye, M.D.

Advance registration fee of $75.00 (payable to Friends Hospital) includes lunches at Friends Hospital both days and dinner Thursday evening at the Marriott Motor Hotel. Category I credit.

Friday, October 10

Morning

"Psychosomatic Specificity: A Reconsideration"—George H. Pollock, M.D.

"The Nature of Psychosomatic Phenomena: A Reconsideration"—John C. Nemiah, M.D.

"The Role of the Family in the Treatment of Psychosomatic Disorders"—Ronald Liebman, M.D.

Afternoon

"Clinical Applications of Psychosomatic Theory"—Panel Discussion
John J. Schwab, M.D., Chairman (George H. Pollock, M.D., John C. Nemiah, M.D., Ronald Liebman, M.D.)

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practice management

Selecting and obtaining the best office—part two

LEIF C. BECK, LL.B. VASILIOS J. KALOGREDIS, J.D.
Bala Cynwyd

In this second part of our series on selecting and obtaining an office, we shall deal with some of the important considerations in actually leasing an office. This is probably the means by which some 80 percent of medical practice offices are obtained, the reason why we give that subject such special attention.

In most cases, leasing office space will provide a practice with the flexibility so important to success. If the office turns out not to be most satisfactory, it can be abandoned at the end of the lease term with a minimum of financial or emotional loss.

Entering the lease transaction is nevertheless a serious business step which will probably commit some 5 percent to 8 percent of the practice's gross income each year. The physician certainly should give careful attention to the details of the underlying lease document. Unfortunately, however, both when moving into a newly rented office and when renewing an existing rental arrangement, a doctor may fail to consider what the lease provisions really mean to him. The following brief comments about lease negotiations will hopefully be helpful.

General negotiating attitude—First and foremost, any doctor contemplating entering a lease should have the document reviewed carefully by an expert advisor, typically an attorney. Even standard preprinted form leases tend to vary rather dramatically, and what actually appears therein can become of vital importance in the future. As an example, a real estate agent's friendly comment that the landlord is flexible and will provide services or improvements not stated in the lease are worthless, for only the finally signed document determines what each party's rights and obligations really are. An attorney will understand what that document actually provides in questionable areas and can check any oral promises against the document for consistency.

Furthermore, a medical practice can often obtain favorable provisions not existing in the originally offered lease. Landlords tend to be fairly reasonable, particularly if their buildings are not yet fully leased out. A variety of special arrangements such as options to renew, individualized "escape clauses," and the like may be extremely important to the practice moving into the office and in many cases will not be that adverse to the landlord. Having an attorney or other advisor who understands these ideas and can express them to the landlord should be well worth any fees involved.

Length of lease—In our view, practices tend to make mistakes by entering into long term leases. The excuse for the longer term undertaking is obviously that it guarantees a constant rent which diminishes in "real dollars" as inflation raises the cost of all other items. As medical practices tend to grow, however, whether by adding more doctors or assistants or by expanding each doctor's patient volume, the physical office requirements tend to change. Similarly, practice patterns may change over the years as, for example, the doctor moves his work to a different hospital or the patient load begins coming from a different area.

Because of these concerns, a fairly short term lease is usually preferable even if it might result in an increased rental rate upon its earlier renewal. It may be desirable to accept the increasing lease obligation, probably just paralleling inflation, to avoid being "locked in" to an office which has become unsatisfactory.

One desirable approach towards obtaining reasonable rental rates over an extended period without losing flexibility would be to obtain several "options to renew" the lease. For instance, a three year lease with two successive options to renew for three years each at rental increases of perhaps $.50 per square foot might be preferable to a single nine or ten year lease at a lower constant rate. The option to renew merely gives the tenant (the medical practice) a *choice* at the end of the lease term either to continue renting the office for an additional period or else to move out with no penalty.

Escalation clauses—Office leases are increasingly including provisions calling for the rent to escalate in some predetermined manner over the lease term. These are known as "escalator clauses," which need not be absolutely unacceptable so long as they are tied to reasonable measuring systems. For instance, a landlord might well be justified in increasing the rent because real estate taxes or utility charges force his own costs to increase beyond what he had anticipated.

Some leases tie the rent to the general cost of living by calling for increases in proportion to the "consumer price index" increases. This is not the most desirable arrangement, as the last few years of inflation would demonstrate, and a physician should attempt to avoid the proposition.

Escalator clauses tied to increasing real estate taxes and utility charges, on the other hand, are quite common. They must, though, be very carefully reviewed to assure that the "base rentals" are fair. For instance, if the tenants are to share any increases in a new building's real estate taxes one must assure that the base tax figure was assessed on a valuation for the building in *completed* form. Tax assessments on new buildings often lag as much as a year beyond completion, thus making possible the trap of almost assured increases unrelated to inflating costs. The same is true with escalator clauses tied to utility charges if

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during the base period the building was not yet fully occupied—the trap is that the total utility charges would obviously be lower before all tenants have moved in.

Escape clauses—Especially in the case of a solo practice, the doctor's lease should provide some opportunity for termination in case of his death, long term disability or call to military service. Without such an "escape clause" the doctor or his estate could be liable for continuing rent even for years after his untimely absence or death. Landlords are often receptive to some type of provision permitting a sole practitioner to terminate the lease after perhaps three months' or six months' notice in the event of such named occurrences beyond his control.

Incorporated sole practitioners should recognize the same need for an escape clause. Although the tenant named in the lease will properly be the corporation rather than the doctor, the escape clause could still be related to his departure, as he is the corporate tenant's sole source of income.

An alternative to the escape clause, though not as satisfactory, would be the right to sublet the office. Landlords will often insist on the right to approve any person to whom the premises might be subleased, and this can lead to troublesome problems. If the building is not fully rented when the sublease situation arises, a landlord will obviously not be very receptive to a tenant's subleasing to someone who might otherwise become a direct tenant. Nevertheless, as a minimum a physician should press for the right to sublet to any other health-related persons or businesses either without landlord approval or with a provision that the landlord's approval "shall not be unreasonably withheld." While this latter language may be difficult in application, it is better than no right to sublet at all.

Tenant improvements—An area of extreme delicacy in any lease is who shall bear the cost of improving the premises. Particularly if a practice is moving into a new building, there may be extensive costs of installing partitions and plumbing to suit the new practice, laying out new electrical outlets and lighting arrangements, installing new cabinetry and equipment and the like. If the tenant is required to make many of these physical improvements at his own cost, in effect his total rental outlay will be substantially higher than the quoted per square foot rate. On the other hand, a landlord who offers to assume the cost of these improvements has probably already figured that cost into the monthly rental rates.

While these two alternatives for financing improvements may appear equal in cost, adding the costs to the rental rates paid the landlord will probably be far more expensive in the long run. Logic would call for the landlord to reduce the rent once the improvement costs have been paid off, but as a practical matter this rarely happens. Instead, that inflated rent tends to be the "base" upon which rentals are increased as the lease expires. Such experiences make it far more desirable for the physician to borrow the improvement costs from a bank, spreading the payment as though it were rent, but thus holding the rental rate to a lower figure.

Improvements also can cause problems when the tenant moves out of the office. For instance, will the practice be entitled to remove certain cabinetry built in especially for that practice? Will certain equipment affixed to the walls or floors be removable? If there are any doubts about these matters, and in fact if there are any improvements even arguably to be affixed, their handling should specifically be expressed in the lease document with provisions allowing their removal upon lease termination.

Removal of improvements may damage the existing walls or flooring. If the tenant anticipates such a problem it should also be negotaited when the lease is being entered.

Parking—Since adequate parking space is of prime importance to a medical office, a doctor should be careful that the lease assures the continuing maintenance of such space. It is not unusual for owners to expand their buildings (or build entirely new buildings) on what was previously parking area, in which case the desirability of the office itself might become seriously damaged. The problem might be avoided by insistence on a lease provision that the owner will maintain either the same parking area he already has laid out or else that he will maintain a specified ratio of parking spaces to each rental unit.

Practice limitations—One must be very careful to determine whether the preprinted lease "rules and regulations" prohibits certain activities which the doctor might decide to engage in. Typical of such restricted activities would be installation and use of x-ray machinery and/or of laboratory facilities. While x-ray facilities obviously raise the fear of radioactivity, whether or not justifiable in a medical office, they may also require special structural support. Therefore, if there is even the outside possibility that such machinery might be added to the practice in the future, the prospective tenant must both inquire into the building's capacity to hold it and seek specific permission in the written lease.

Redecoration and recarpeting—Some landlords orally express a policy of redecorating and repainting tenant offices periodically, perhaps every three years or five years. The expression, however, is meaningless unless it also appears in the lease document. Without it, the tenant may find that he has no real lever to obtain these benefits except the threat to move out as the lease term approaches its expiration date.

More and more offices are being constructed without finished flooring so that wall-to-wall carpeting is initially provided. While this may be desirable, carpeting tends to wear out in just a few years with the resulting need to be replaced. Particularly since the underlying flooring may not be satisfactory without carpeting, the tenant should seek an express lease undertaking that the owner will replace the carpeting perhaps every five years. This provision can lead to a considerable saving for the medical practice tenant.

Summary—The above are a few of the common areas in which a proposed office lease might become a serious problem for the medical practice. With reasonable care in reviewing the lease and in negotiating with the owner, however, the problems should be capable of solution. Hopefully by these descriptions the reader will be more aware of what he and his advisors should protect against as he considers moving into his new office or renegotiating the lease on his present space.

Laboratory tests denied

Hospital upheld in refusal of chiropractor

LESLIE A. MILLER
Harrisburg

Ms. Miller, a second year law student, prepared this report while spending the past summer working at the Harrisburg offices of Pepper, Hamilton, and Scheetz, the Society's legal counsel.

The recent decision of the U.S. District Court of Oregon in the case of *Aasum v. Good Samaritan Hospital*[1] should be noted with interest because of the limitation it imposes upon the rights of chiropractors to use a private hospital's laboratory. The action was initiated by a licensed chiropractor against Good Samaritan Hospital for the hospital's refusal to permit him to use its clinical laboratory facilities in the treatment of his patients. In upholding the hospital's directive limiting the use of laboratory facilities to members of the medical staff and physicians licensed by the Oregon State Board of Medical Examiners, the Court found that such an order did not constitute unreasonable discrimination in violation of the 14th Amendment. On the contrary, the Court held the hospital's rule distinguishing between physicians and chiropractors to be reasonable and, hence, constitutionally permissible.

The Court handed down its rule after applying the "rational relationship" test to the hospital's rule, which permits discrimination among various classes *if* there is a legitimate connection between such classification and the objective sought. The Supreme Court has said:

> The equal protection clause of the Fourteenth Amendment does not take from the State the power to classify in the adoption of police laws, but admits of the exercise of a wide scope of discretion in that regard, and avoids what is done only when it is without any reasonable basis and therefore is purely arbitrary.[2]

In this particular case, a reasonable basis for the discrimination between physicians and chiropractors was found. Good Samaritan's decision to exclude chiropractors from its medical staff and facilities was made in the interest of providing adequate medical services for the public. The Court found a rational relationship between this purpose and the classifications themselves, because to maintain its accreditation, the hospital must satisfy the Joint Commission on Accreditation of Hospitals which uses the same classification.[3] Good Samaritan chose to follow the commission's standards in selecting its staff, for to do otherwise would have jeopardized its accreditation.

The Court, in this case, saw no reason to deviate from past decisions which have permitted hospitals to discriminate between competent and incompetent physicians[4] in order to provide high quality health care and maintain their accreditation. Hence, it supported Good Samaritan's order excluding chiropractors from its staff and denying them access to its laboratory facilities. No violation of the 14th Amendment was found because the Court believed that the hospital's decision was rationally related to its purpose.

The Court also dealt with the question of whether state action was involved, thus bringing 14th Amendment protections into play. Specifically, the Court addressed the issue of when discriminatory conduct that is of a private nature (such as that of Good Samaritan Hospital) becomes "so entwined with a governmental character as to become subject to the . . . limitations placed upon state action."[5] The court believed that in this situation the decision that caused injury to the plaintiff resulted from Good Samaritan's reliance upon the Oregon Board of Medical Examiners' recommendation that it prevent persons not licensed by the Board from using its facilities. The Court held that this constituted state action. Despite this finding, however, the court was quick to point out that there is no set formula for determining the presence of state action. Rather, the facts of each case must be considered individually, bearing in mind at all times the knowledge that an expansive judicial reading of the statutes can produce drastic changes.

The trend in Pennsylvania has been to limit the diagnostic capacity of chiropractors. In light of such limitations, it would not be unreasonable to expect the Pennsylvania courts to follow reasoning similar to that of *Aasum v. Good Samaritan Hospital* and uphold a private hospital's decision to exclude chiropractors from the use of its facilities.

REFERENCES

1. **Aasum v. Good Samaritan Hospital**, et al., Civil. No. 72-722 (D. Ore., May 19, 1975).

2. **Ibid.**, p. 11, citing **Lindsay v. National Carbonic Gas Co.**, 220 U.S. 61, 78 S. Ct. 337, 340, 55 L.Ed. 369; **Morey v. Doud**, 354 U.S. 457, 463, 77 S. Ct. 1344, 1349, 1 L.Ed. 2d 1485 (1957); accord, **McGowan v. State of Maryland**, 366 U.S. 420, 81 S. Ct. 1101, 6 L.Ed. 2d 393 (1961).

3. The Joint Commission on Accreditation of Hospitals recommends that hospital medical staffs be limited to fully licensed physians, dentists and podiatrists. It does not approve chiropractors.

4. **Hayman v. City of Calveston**, 273 U.S. 414, 47 S.Ct. 363, 71 L.Ed. 714 (1927); **Rao v. Board of County Commissioners** (Pierce), 80 Wash. 2d 695, 698, 497 P. 2d 591, 592-93, (1972), *cert. denied* 409 U.S. 1017.

5. **Ibid.** p. 2.

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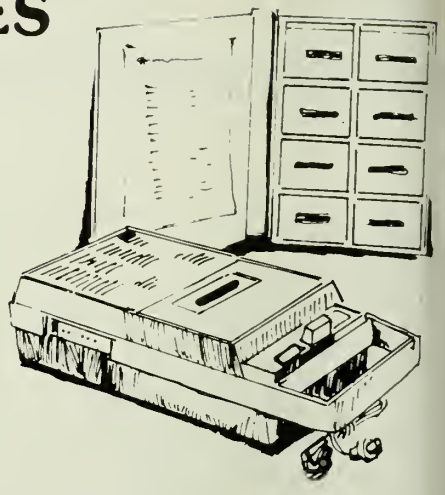

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Society testifies on bioavailability, bioequivalence

Spokesman Arthur H. Hayes, Jr. M.D., chairman of the Society's new Commission on Therapeutics, asked committee members some pertinent questions when he stated the Society's position on a bill calling for generic drug substitution. His testimony follows.

Arthur H. Hayes, Jr., M.D., testified on behalf of the Pennsylvania Medical Society on August 6 before the Committee on Health and Welfare regarding House Bill 473 on generic drug substitution. Dr. Hayes is chairman of the Society's new Commission on Therapeutics to which all such legislation will be referred.

My name is Arthur H. Hayes, Jr., M.D. I am associate professor of medicine and pharmacology at the Pennsylvania State University College of Medicine in Hershey and am chairman of the Commission on Therapeutics of the Pennsylvania Medical Society. My remarks are made on behalf of the Pennsylvania Medical Society and its 13,000 members.

The Commission on Therapeutics was established during this past year specifically to advise the Pennsylvania Medical Society on matters of drugs that are too technical for most of the members to judge. The resolution that created the commission specified that two members should be clinical pharmacologists, one should be a basic pharmacologist, two should be specialists in internal medicine, one should be an anesthesiologist, and one should be a pediatrician.

One of my first actions as a member of this commission was to review the literature on drug bioavailability and drug bioequivalence. These are terms that are familiar to pharmacologists but not necessarily understood by the rest of the population. Bioavailability indicates the rate and extent of a drug's reaction in your body. Reputable drug manufacturers are expected to maintain the same "bioavailability" in each different batch of the same drug that they manufacture. Bioequivalence is the word that is used to indicate that two drugs have the same chemical composition and similar binders (the stuffing that keeps the pill together) and also similar covering substances so that they will react *essentially* the same when a patient takes one or the other. "Essentially the same," I said, because a drug in a capsule with a red cover will never react in the body the same as the same drug in a capsule which has a red and white striped cover. Even the amount of coloring substance will have a slightly different effect when it is absorbed in your body. Sometimes, the differences are so small as to be unimportant and then the capsules can be considered "bioequivalent."

My second inquiry as a member of this new commission was to determine what generic drugs were proven to be bioequivalent to brand name drugs. A brand name is given to a drug when a company develops it and patents it. Naturally, the patent allows the company to establish its product as the standard. When the patent protection runs out, other companies are free to bring out generic versions. "Generic" means general—within the same family. It's like the beer or soft drink families—essentially the same but not exactly the same. You must remember, however, that we are not talking about anything as harmless as an "uncola." We are talking about drugs. Drugs that could have a lasting or even disastrous effect on your body!

When we speak of substituting generic drugs for brand name drugs we are saying two things. First, that someone has tested in a laboratory and in humans certain products in the same drug family. This is not a one-time operation. It must be done over and over so that there is no doubt but that the manufacturer of the generic drug can really produce the same product each time he manufactures it. (No one wants to approve a product that is being manufactured in a boiler in someone's basement in Brooklyn.) Second, we are saying that the tested generics have met the requirements of bioequivalence—being essentially the same as the brand name drug which is used as the standard measurement.

This is extremely difficult. The members of our Commission on Therapeutics could not possibly accept such responsibility because we do not have sufficient time, laboratory facilities, and technical assistance. How could you expect any council of political appointees to succeed in

such a difficult area? The Federal Food and Drug Administration has been trying to do it for at least three years and has not succeeded. In July they lost a court suit because they had allowed a manufacturer to sell a generic drug (a tranquilizer much like Librium) without an approved "new drug application."

The American Medical Association is at the present time preparing a lawsuit against the Department of Health, Education, and Welfare charging that their procedures to set maximum allowable drug cost regulations will interfere with the physician's Constitutional and statutory rights to practice medicine—and with the patient's right to receive his physician's best medical judgment. Maximum allowable cost (MAC) is a federal program which, under Medicare and Medicaid, provides for reimbursement for the cost of generic drugs, not for brand name ones.

The AMA is saying that when HEW substitutes generic drugs for brand name ones it also takes upon itself the responsibility for quality control that was formerly exercised by prescribing physicians. Physicians in general use the brand name drug as their quality control. They know from years of experience with a manufacturer that they can depend on a certain reaction from any given drug. If a manufacturer betrays this trust, the physician stops prescribing the product. He has no capital tied up in stock on the shelf. He receives no income from the prescription he writes. His only interest is in the best product to do the best job for his patient.

If the pharmacist makes the decision regarding the drug, based on the lowest cost, someone must worry about the quality of drugs that are made in every chemical shop in the nation. Whether it is HEW or the Commonwealth of Pennsylvania, it implies an army of government inspectors, all devoted to solving a problem that the doctors formerly handled with a stroke of a pen. When a pharmacist prescribes medication from a list that has been provided by a government agency, there also could be abrogation of the Pennsylvania Medical Practice Act.

Many questions were discussed by our Commission on Therapeutics as we reviewed this bill. I will simply list some of them so that you will understand the breadth of our interest.

- Who will prepare the lists that the pharmacist will use?
- Who will inspect pharmacies?
- Who will issue instructions and interpretations of the law?
- Who will review the requests for new drug approval?
- Who will inspect manufacturers to be sure that the product remains the same?

  The fact that a generic drug has been originally tested does not guarantee continued bioavailability since the FDA cannot and does not inspect all drug manufacturers and the frequency of inspections is probably less than optimal even for those firms that are being inspected. (Are you aware that there is no one in the United States of America who even pretends to know how many drug manufacturers there are in this country?)
- Who is liable if the patient has a bad reaction to a substituted drug?

We also considered questions about the patient's reaction to all of this.

- Will the patient consider the pharmacist's judgment as good as his physician's?

  The State of Michigan has a law which allows substitution of drugs. It became effective April 1 and allows the consumer to request the least expensive drug. To date there has been very little consumer participation and no one can say why. Could it be that in matters of drugs the consumer doesn't want the "cheapest?"
- Who will be responsible for the communications with the patient?

  You realize, of course, that substitution will give the patient a different color, shape, and/or size pill or capsule. It is difficult enough using the same brand drugs to obtain proper patient instruction and compliance. Imagine a patient who is receiving three different kinds of medication, all of which may be substituted without prior knowledge of the physician and with different substitutions from time to time. The conversation might go as follows: "Mr. Jones, instead of one red pill three times a day, you will be taking one green pill three times a day. Instead of one green pill every morning, take one yellow capsule; and instead of the two yellow pills four times a day take one red capsule four times a day." This may not be a very serious problem for you or for me but what of the aged and the poor?

I am sure that House Bill 473 was proposed to save money for the consumer. Have you considered, however:

- Who will pay for the long distance telephone calls or the postage that is required to notify the prescriber of the substitution?
- Who will pay for the pharmacist's time, materials, and extra staff that will be needed to maintain additional records of notices mailed and reasons for substitutions?
- Who will pay for the physician's time, additional materials, and extra staff time that will be required to change records so that these substitutions are taken into account in future treatment of the patient?

This bill seems to increase costs to the patient, the pharmacist, and the physician, and in addition creates a giant bureaucracy. But let's assume for a moment that the consumer breaks even, that the bureaucrats' salaries are offset by lower drug company profits. What have you then done? You have (as was recently pointed out in the July 10 issue of the Wall Street Journal) taken money that would go into drug research and other capital investments and paid it instead to bureaucrats hired to solve a problem that didn't exist until the bureaucrats caused it.

The medical profession in the State considers this in no way progress!

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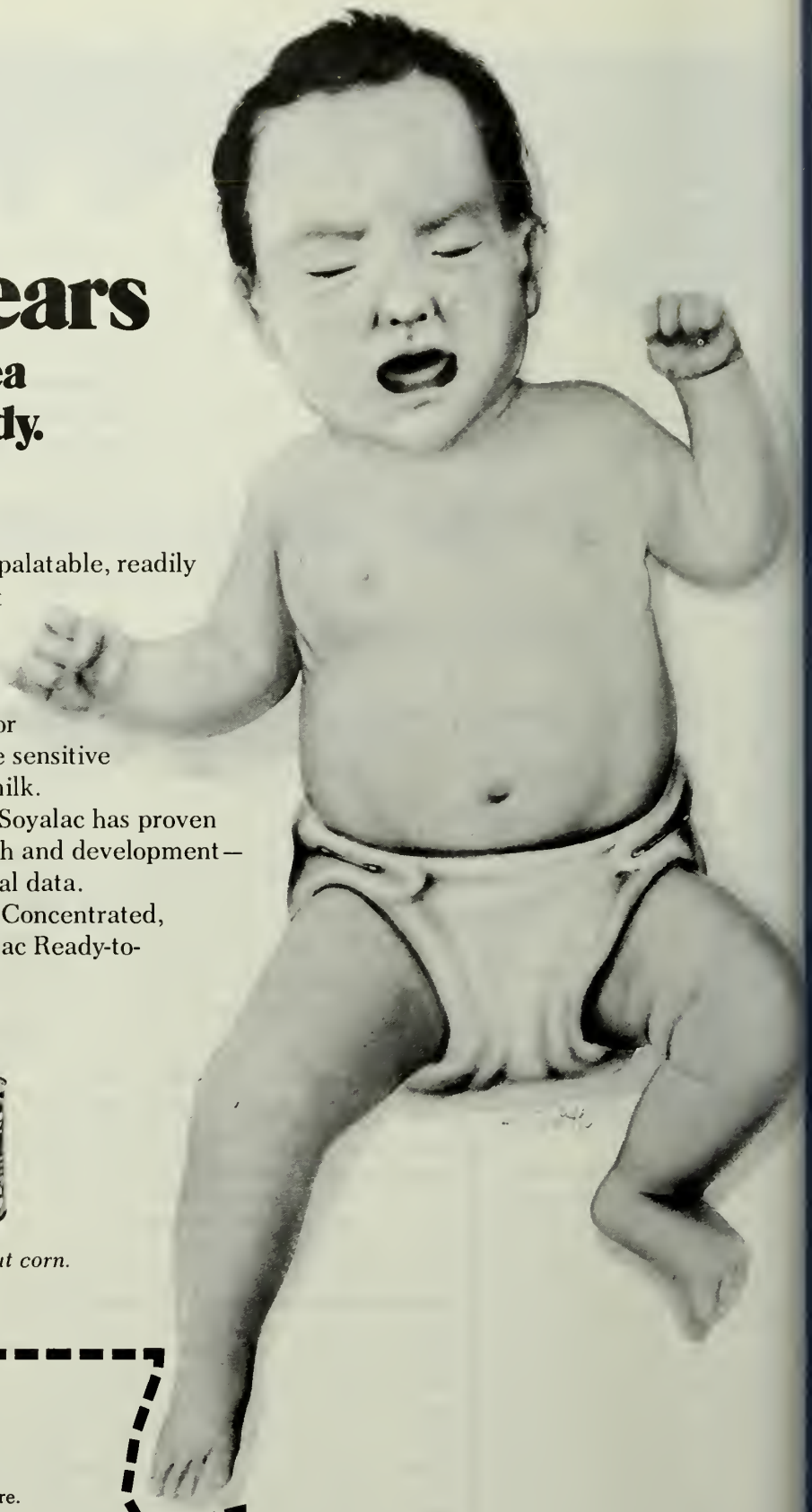

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Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

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Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients, history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia, history or presence of drug allergy, blood dyscrasias; renal, hepatic or cardiac dysfunction, hypertension, thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug, polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals. Careful detailed history for disease being treated and detection of earliest signs of adverse reactions, complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug, its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.

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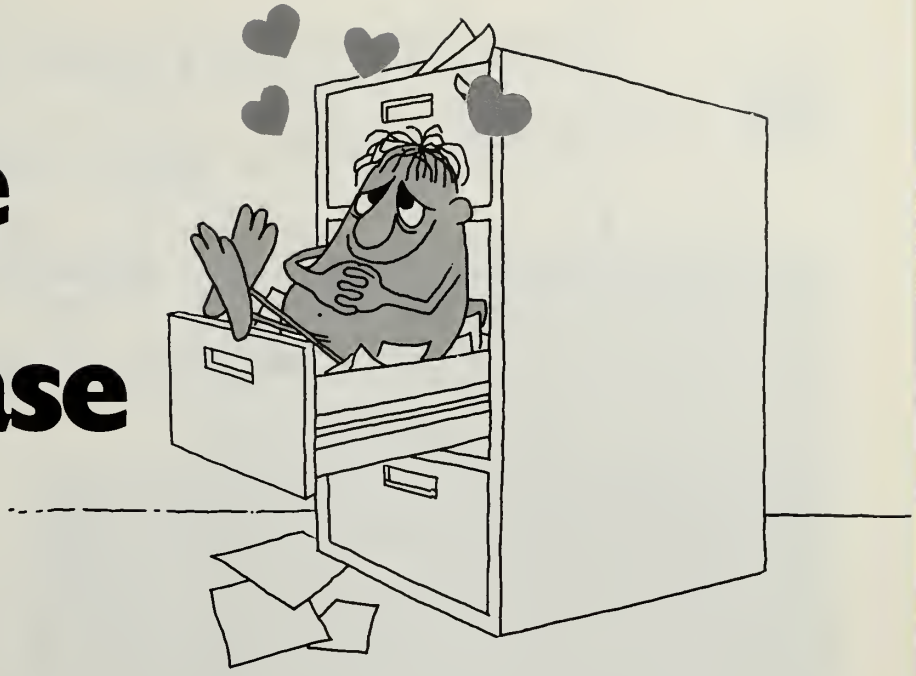

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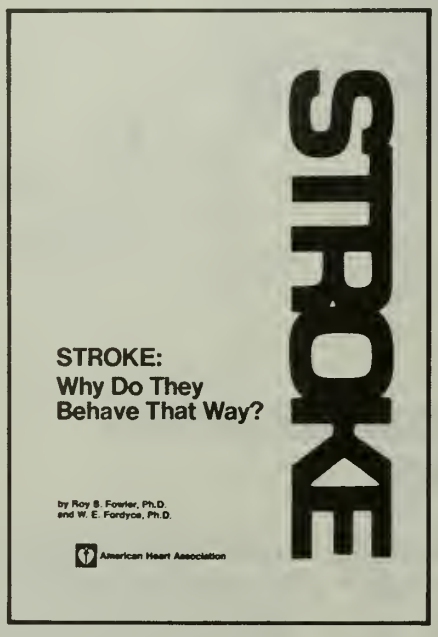

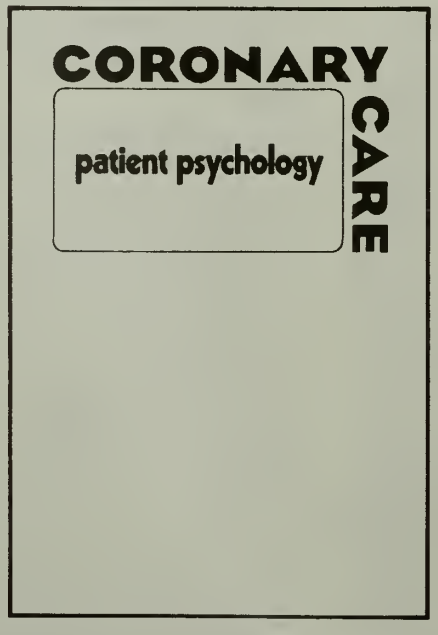

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CORONARY CARE: PATIENT PSYCHOLOGY b Thomas P. Hackett, M.D. and Ned H. Cassem, M.D. Th booklet describes the psychological problems that often a encountered in dealing with coronary patients. The effect certain experiences such as witnessing cardiac arrest being resuscitated are discussed as well as the problems anxiety, depression and management difficulties. Patie education, physical reconditioning and drugs are offered a solutions in patient management.

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The foreign medical graduate—an effort at definition

RONALD E. COHN, M.D. F.A.C.P.

EUGENE G. GRACE, III

FRANCES MAGDZIAK, C.M.A.

Philadelphia

'There must be a continuum of interplay between the foreign graduate and society at large via mechanisms of medical societies and the lay society to assure a total and comprehensive integration of the physician into the system. . . .'

Dr. Cohn is medical director of Frankford Hospital and chairman of the Philadelphia County Medical Society Committee on International Medical Affairs. Mr. Grace is immediate past director of INTERMED, and Ms. Magdziak is a medical assistant at Frankford Hospital.

In 1974 Weiss,[1] writing in the *New England Journal of Medicine*, described the "medical underground." Since that time a proliferation of articles on this and related subjects, supported by charts, diagrams, and numbers, have appeared in the literature. After studying these one cannot help but arrive at a biased adverse conclusion that could lead to a closing of our doors to such a poorly prepared group who might ultimately destroy the system of medical care as we now know it. Our effort here will be neither to support nor refute the individual commentaries that have previously been written, but rather to shed some light on them. Our experiences here in Philadelphia might lead the reader to more reasonable conclusions as to a rational approach to this "problem."

Definition of the problem

Physicians and medical educators continue to speak of the foreign medical graduate physician as a new problem when in fact immigrant physicians have been escaping from atrocities, persecutions, discrimination, and poor economic situations for as long as this country has existed. Many simply took on new identities and were never successful in entering the United States' medical system. Others were able to enter and succeed in various dimensions. No one has argued with their need to enter the United States nor have we minded the use of them in supplying the service requirements of our educational programs when it was convenient. The concern and its current magnitude are now fueled by the increasingly large body of statistical data which indicates, among other things, that 46 percent of all new physicians currently entering practice and receiving licenses as of 1972, and al-

most 20 percent of *all* practicing physicians in the United States are foreign medical graduates.[2] This same article expressed the fact that we have already reached the time when the influx of new foreign graduates exceeds those of our own medical education process.

It is not our purpose to repeat the numbers often verbalized to those of us involved in addressing this problem, but rather to point out that, albeit there is a need to arrive at a long term master plan for resolution of the problems of entry, testing, certification and numbers for the medical graduate, there is a more pressing need to address ourselves more comprehensively to the need of those who are already here or will be arriving in the forseeable future.

We have been impressed that these problems break down into two primary areas. The first is the competency issue and the second involves the "culturalization" issues. The former of these lies perhaps more correctly in the province of the various educational review committees. The latter, however, is one in which the Philadelphia experience is quite broad and it is to this that we will direct most of our comments.

Competency

No one can convincingly argue against the hard data indicating that foreign graduates on the whole demonstrate less proficiency in basic knowledge of medicine on entrance to our system when contrasted to graduates of medical schools in the United States and Canada. The range, however, is quite broad and there are numerous exceptions to this. The Educational Council for Foreign Medical Graduates examination is made up of questions which would be answered correctly by most American graduates. Results of FMGs tested tend to cluster around 77 percent to 70 percent. Of American graduates, 98 percent would be expected to achieve scores of 75 percent or more on this examination as contrasted to broad failures of FMGs. If this is so, then why not administer the same qualifying examination to all graduates, foreign and American alike, prior to entrance into our graduate educational system as suggested by others?[3,4]

Our problem is really one of lack of coordination between the many groups, agencies, and committees at all levels addressing themselves to this with the concomitant failure to define a master plan. Is it really reasonable that an examination given over six and one-half hours should allow an unknown candidate, except for credentials, which none of us is qualified to evaluate by our own admission, to bypass the entire American educational system of checks and balances?

How can we contain our dismay when our great educational institutions tell us that no one has ever made a sustained effort to study the capabilities of the various foreign medical schools to which our own students are now applying in even greater numbers and from which so many physicians are now coming into the United States to practice? How is it that an English examination can be given without anyone ever spending a few minutes to attempt communication with a candidate, which surely would be more useful in evaluating the basic ability to communicate than a written examination. The latter is and has been done very adequately by the Student American Medical Association in its foreign medical student exchange program where a simple letter of verification of communicative ability is provided after examination in the country of origin by a qualified agency.

We do not wish to belabor this point but would express our disagreement with Dr. Tan[5] who states that we should assume at our expense a one month program for the English education of the foreign graduate. We feel it is the rightful responsibility of the immigrating medical graduate himself to accomplish this prior to arrival or at least to arrange for it except in unusual circumstances. We do feel the need for a basic indoctrination in areas such as slang after arrival, on which we will further comment below.

Numerous individuals have stated that the age and level of activity of the foreign medical graduate disadvantages him on examination. There can be little question that our own physicians at a later stage in their lives and development would be unable without a good deal of effort to prepare themselves to cope with an examination in the broad field of the basic sciences as well as the clinical specialties. This is particularly so if they have migrated to a limited specialty of their own.

Nonetheless, we have been impressed that those physicians who desire to practice in later years in what they consider to be more desirable locations for one reason or another seem able to take the time and expend the energies to sit down and hammer out a review which ordinarily turns out to be a very useful exercise for them over the long run. Many of these physicians have commented on how refreshing it was to go back to the basics after being away from them for so long. It is difficult to understand that the physician who is truly interested in emigrating to a new land would not be willing to make the same kind of commitments as the physician attempting to relocate within the United States. We are impressed that many of the foreign medical graduates could have done more in their self-preparation which certainly would have been assured by more exacting entry examinations. Without such a formal exercise at knowledge, is it really rational for us to assure the lay public that the house officer will, in fact, have the wherewithal to do the job?

Physicians graduating from various medical programs over the world are not equivalent. There is no necessity for a medical school in a developing country to provide the education necessary for practice in the city of Philadelphia, Pennsylvania. The needs are different, the communities are different, the disease entities are different, and the people themselves are different. If the needs of the United States are for primary care physicians then does it not make sense that the new physician coming into this country meet our standards or, failing that, enter some prescribed program of preparation which allows him or her to subsequently meet those standards.

Fortunately, most foreign medical graduates coming into the United States do stay in educational programs for several years. Once they

finish these programs, however, they usually finish as specialists and do not therefore address themselves to our need for primary care physicians. Additionally, they contribute in general to the maldistribution of specialists congregating in the cities where they are less frequently needed.

At a recent meeting of the United Fund in Philadelphia, the question was raised as to whether the great influx of foreign graduates might even be disadvantaging our black and other minority students in that efforts to expand medical schools here would be inhibited if the number of immigrants was enough to fulfill the needs of the community. This is a fascinating twist which should lead to some soul searching on the part of all of us.

Culturalization

The above framework should not be construed to be a negative one but rather a realistic one which recognizes the situation as it exists and emphasizes the needs for evaluation to occur before the FMG arrives. Once here, however, it is mandatory that national, state, and local policies assure that the FMG entering the United States is assimilated into the medical system as quickly and completely as possible, and that he be made as comfortable as possible and that he be made an integral part of that system without regard to race, creed, color, sex, or ethnic origin. It is our purpose as a profession and more broadly as Americans to make these new arrivals comfortable, welcome, and functional as quickly as possible. This assimilation must include not only the medical practice piece but the community or general piece as well. It would seem appropriate therefore to address ourselves to some of these latter areas in more depth.

In contrast to the immigrations of the past, the bulk of new foreign medical graduates come from the Far East. The cultural and physical differences between these graduates and those which we were more used to in the past exaggerate the problem. The change from the Germanic, Romance or Anglo-Saxon languages to English is not nearly as difficult as that from Thai, Korean, Chinese, etc. Those trained in this area could certainly comment more wisely in this regard, but suffice it to say that physical appearance, culture, and language have played a tremendous and obvious part in the difficulties encountered by this group in acclimating to our system.

The cultural aspects are legion and there are many stories and experiences which emphasize them. We are reminded of two Thai graduates of the same medical school, a male and female, who had not spoken to each other very much in Thailand because "boys and girls just don't talk to each other." Certainly they were acutely thrust upon each other here and, while adjusting to that as well as the other aspects of cultural shock, were trying to provide a continuum of patient care at the same time.

Many FMGs have predetermined ideas of this being a land of "milk and honey," of the crime rate in the United States, of our attitudes on foreign policies such as the Vietnam conflict, and so on.

Many come into the country with distorted ideas of finances and what they will be able and not be able to buy with the dollars they earn. Our high salary levels which seem to buy very little in this country look exorbitant to them in reference to their own monetary systems. Many come from countries with currency restrictions and arrive without adequate funds. Although most hospitals seem to be advancing dollars against salaries, some city hospitals because of city charters are unable to advance anything and therefore the physician must seek loans from sources outside or personal loans from members of the medical staff or other hospital family.

Many suffer severe emotional problems trying to resolve their own intentions to emigrate against the wishes of their country, as noted in the skills list[6] which has been in effect since May 1972, and known restricted practices in their own nations, such as minority discrimination, which will impact on them if they are required to return there.

The draft was a threat to the FMG until it was withdrawn. The elimination of this may now be impacting in a positive way on the inflow of new physicians.

Suitable housing is frequently a problem. Our concept of what is suitable in housing may differ from that of the FMG. Many are unable to drive when they come into the United States and therefore transportation may be an immediate and real problem. This is a country of the automobile and even city dwellers experience the effects of not owning an automobile.

Many schools discriminate against children despite laws to the contrary. Larger school systems may "dodge" the issue; smaller schools do have a problem in terms of providing expertise to meet the language and other individual needs of a youngster with a language problem and little support in the home environment.

Little attention is paid in any quarters to a physician's wife who tends frequently to withdraw into her own apartment sheltered from the "foreigners" who do not speak her language. Little attempt is made on the part of the local medical society, hospital, or the community at large to integrate the spouse into the system which only exaggerates further the frustrations, irritation, and even chaos for the total family unit. Generally, doctors' wives clubs, hospital auxiliaries, or the lay community at large have shown inadequate interest in meeting the needs of these people, needs sometimes of a purely emotional nature.

The needs of the new physician are not limited to knowing where the coronary care unit is, but include orientation to schools, supermarkets, social security numbers, bank accounts, telephones, transportation facilities, shopping mechanics, currency, and much more. The list is endless. One need only be reminded of the aggravations encountered in moving from one state to another and trying to get a new driver's license, new bank account, and so on, to approach an understanding of the frustrations exaggerated by the inability to communicate.

Observations

Despite the plethora of problems either described or alluded to, there are rational solutions to them. A general test of medical knowledge which all physicians would take for which no

one could level any criticism should be administered to all candidates for medical practice regardless of background. Passage of this test would eliminate the overt questions of inferiority. Such a test should be administered only after a mechanism is established which would assure fluency of the English language. Beyond this which we consider to be obvious and rational, we would suffice in this treatise to say little more regarding the medical knowledge piece of the problem than this: that any institution in which FMGs make up a part of the educational program has an obligation not only morally and ethically but by edict of the boards of the various specialties and the Council on Medical Education of the American Medical Association to assure that that program is a bona fide educational experience. Page 152 of the *Directory of Approved Internships and Residencies*[7] under "Essentials of an Approved Internship" states: "In addition to the foregoing requirements for all interns, those programs which accept graduates of foreign medical schools should contain certain *special additional features* which are essential to the effective education and training of such individuals." This article goes on to say that this will include orientation for the FMG including thorough familiarization with the patterns of American hospital and clinical practice, organizational responsibilities of hospital personnel, legal as well as moral and ethical concepts of physician-patient relationships in the varying patterns of graduate medical education which lead to competence in practice. Suffice it to say that we will hope to see increasing emphasis in this area by the American Board of Medical Specialties.

We in Philadelphia are extremely fortunate to have been leaders in establishing the INTERMED program for the assimilation of international medical visitors, both physicians and nurses and their families. This is not to say that we have all the answers but rather that we have at least begun to approach them in a defined way including several annual symposia on the subject of what the problems are and what potential solutions are open to us. Let us further indicate that we have also encountered numerous problems, resistances, and other kinds of barriers which have not allowed for the optimal cooperation which we would have hoped for in carrying things to completion.

During our discussions, we have exhaustively reviewed the possibilities of establishing programs of education on arrival. The ability to do this does not come easily and varies much from locality to locality. Getting foreign graduates to your hospital prior to the beginning of the formal educational program is difficult for many reasons despite the many good intentions.

A place for them to live is, of course, one of the earliest and most pressing problems. The host family concept seems to be coming into its own but is as yet an untapped reservoir. Most hospitals do not have the facilities or the dollars to pay for the expanded time frame of the initial educational year and here in Philadelphia there is an increasing effort on the part of the local Blue Cross to disallow any costs relative to education.

The timing is frequently incorrect for the foreign graduate as he is finishing up a program too late in his country of origin and cannot get here on time. Delays are encountered with the Commission on Foreign Medical Graduates and the DSP-66 forms which are being corrected. The simple exchange of letters sometimes are impacted on by inadequate postal systems in these countries. We have experienced situations in which letters sit for as long as thirty days or more in post offices with no effort apparently to deliver them to the addressee.

All of these problems to the contrary, there must be at each institution in each locality a way to afford the people entering the program ample opportunity for the imparting of information to them before they are thrust into the system delivering medical care and not really knowing what the implications are. We have not been impressed with the ability of the foreign medical graduate to grasp information sent ahead of time by mail. They just do not grasp its relevance until they are actually here at the hospital.

In those countries where there are significant numbers of graduates who will be coming to the United States, a pre-departure orientation program could be designed. If necessary, it would be in the interest of our government and our educational system to send knowledgeable people to Korea, to Thailand, to the Philippines to indoctrinate large groups of people who will be coming the the United States. This could still allow for a reemphasis for most in this country and perhaps even in some programs for the only emphasis that they will get on the American medical care system. Indoctrination programs are necessary for both the physician and his/her spouse as to social and cultural considerations.

INTERMED, over the several years in which it has functioned as a program of the Philadelphia Council for International Visitors, has been quite successful in working with hospitals toward this end. Currently, this activity is now being taken over by the Nationalities Service Center of Philadelphia, a United Fund agency, on an experimental basis to see whether or not this can effectively be integrated into their overall approach to welcoming new immigrants and long term visitors to this area.

There must be a continuum of interplay between the foreign graduate and society at large via mechanisms of medical societies and the lay society to assure a total and comprehensive integration of the physician into the system. It is impossible to assume that a physician no matter how well educated could manage the emotional and other problems of our neighbors without having had the opportunity to develop in our system and understand why these things are as they are. □

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• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Harry Wenzel Baily**, Tamaqua; Jefferson Medical College, 1917; age 82; died June 14, 1975. Dr. Baily was a past president of the Schuylkill County Medical Society and the Lehigh Valley Medical Society. He served as president of the Tamaqua Board of Health for 32 years and a member for 53 years. In 1974 he was named Outstanding Citizen of the Year by the Tamaqua Area Chamber of Commerce. His wife and a sister survive him.

• **Victor J. Baluta**, Shamokin; Jefferson Medical College, 1924; age 79; died June 15, 1975. He received the State Society's 50 year award in 1974. Three daughters, a brother, and a sister survive him.

• **Edward Cleaver Crowl,** Bloomsburg; Jefferson Medical College, 1926; age 74; died July 6, 1975. His wife and two sons survive him.

• **Felix C. Feamster**, Chambersburg; Medical College of Virginia, 1940; age 61; died June 22, 1975. He is survived by his wife, a daughter, a son, and a brother, Robert C. Feamster, M.D.

• **James A. Griffiths**, Pottstown; Temple University School of Medicine, 1934; age 69; died June 6, 1975. He was chief radiologist at Pottstown Memorial Hospital from 1947-71. A son, two daughters, two brothers, and a sister survive him.

• **John H. Harris, Sr.**, Harrisburg; Washington University School of Medicine, 1923; age 79; died July 1, 1975. Dr. Harris was president of the State Society 1967-68, of the Dauphin County Medical Society in 1948, and of the Pennsylvania Division of the American Cancer Society 1948-50. He was on the American Cancer Society National Board of Directors 1950-54. Dr. Harris was a director of Capital Blue Cross for thirty years and a founding member of Pennsylvania Blue Shield. During his 41 years as a State Society member he served on the Council on Governmental Relations, the Committee on Objectives, the Special Committee to Study the Relations between Medicine and Osteopathy, and the Advisory Committee to the Executive Director. Two sons, John H. Harris, Jr., M.D., and William H. Harris, M.D., survive him.

• **Aaron Henry Heisey,** Quentin; Hahnemann Medical College, 1939; age 60; died July 10, 1975. He had been Lebanon County Coroner since 1954 and was well known in the area for his great interest in youth and the poor. He is survived by his wife, a sister, and four sons, two of whom are Robert G. Heisey, M.D., and Ronald B. Heisey, M.D.

• **LaRue M. Hoffman,** Williamsport; University of Pennsylvania School of Medicine, 1919; age 80; died July 6, 1975. He was past president of the Lycoming County Medical Society and had served in other capacities. He was past president of the staffs of Divine Providence and Williamsport Hospitals. His wife, a daughter, and four brothers survive him.

• **K. Ting King**, Wyndmoor; St. John's Medical School, Shanghai, 1941; age 58; died June 7, 1975. He was chairman of the anesthesiology department at Chestnut Hill Hospital and assistant clinical professor at Jefferson Medical College. He is survived by his wife and four daughters.

• **Edward Martin, Jr.**, Johnstown; Tufts University School of Medicine, 1945; age 55; died July 13, 1975. He was director of the department of anesthesiology at Mercy Hospital. Information regarding survivors is not available.

• **Hans May,** St. Croix, Virgin Islands; Albert Ludwigs University, Badeu, Germany, 1926; age 73; died July 23, 1975. He was associate professor of surgery at the University of Pennsylvania Graduate School of Medicine and past president of the staff of Lankenau Hospital. He was a diplomate of the American Board of Surgery, a member of the Founders' Group of the American Board of Plastic Surgery, and co-inventor of the Engel-May Two-Plane Direction and Range Finder for repairing broken hips. His wife and two sons survive him.

• **William W. M. Mills, Sr.**, McMurray; University of Pittsburgh School of Medicine, 1904; age 94; died June 23, 1975. Two sons and a sister survive him.

• **Albert M. Morton,** Philadelphia; Howard University School of Medicine, 1921; age 81; died April 11, 1975. Information regarding survivors is not available.

• **William A. McNamara,** Scranton; University of Pennsylvania School of Medicine, 1943; age 56; died June 12, 1975. He was chief of staff of obstetrics and gynecology at Community Medical Center. His wife, a daughter, and a son survive him.

• **Edward Pardoe**, Bryn Mawr; University of Pittsburgh School of Medicine, 1909; age 89; died June 29, 1975. Information regarding survivors is not available.

• **Anthony S. Quinto**, Levittown; Hahnemann Medical College, 1967; age 34; died June 13, 1975. He was assistant professor of surgery at Hahnemann and Philadelphia General Hospitals. He is survived by his wife, a son, a daughter, his parents, a brother, and a sister.

• **Eugene K. Weiss**, Clarks Summit; Temple University School of Medicine, 1934; age 67; died July 3, 1975. He was a diplomate of the American Board of Neurological Surgery, and a member of the Harvey Cushing Neurosurgical Society, the Philadelphia Neurosurgical Society, and the Philadelphia Neurological Society. His wife, two sons, two brothers, and two sisters survive him.

• **John Howell West**, Phillipsburg, NJ; University of Pennsylvania School of Medicine, 1913; age 89; died June 22, 1975. He founded the pediatric ward at Easton Hospital in 1924 and was its chief until 1946. Information regarding survivors is not available.

Bernard A. Balsis, Trenton, NJ; Hahnemann Medical College, 1937; age 63; died June 6, 1975. He is survived by two daughters, two sons, a sister, and a brother.

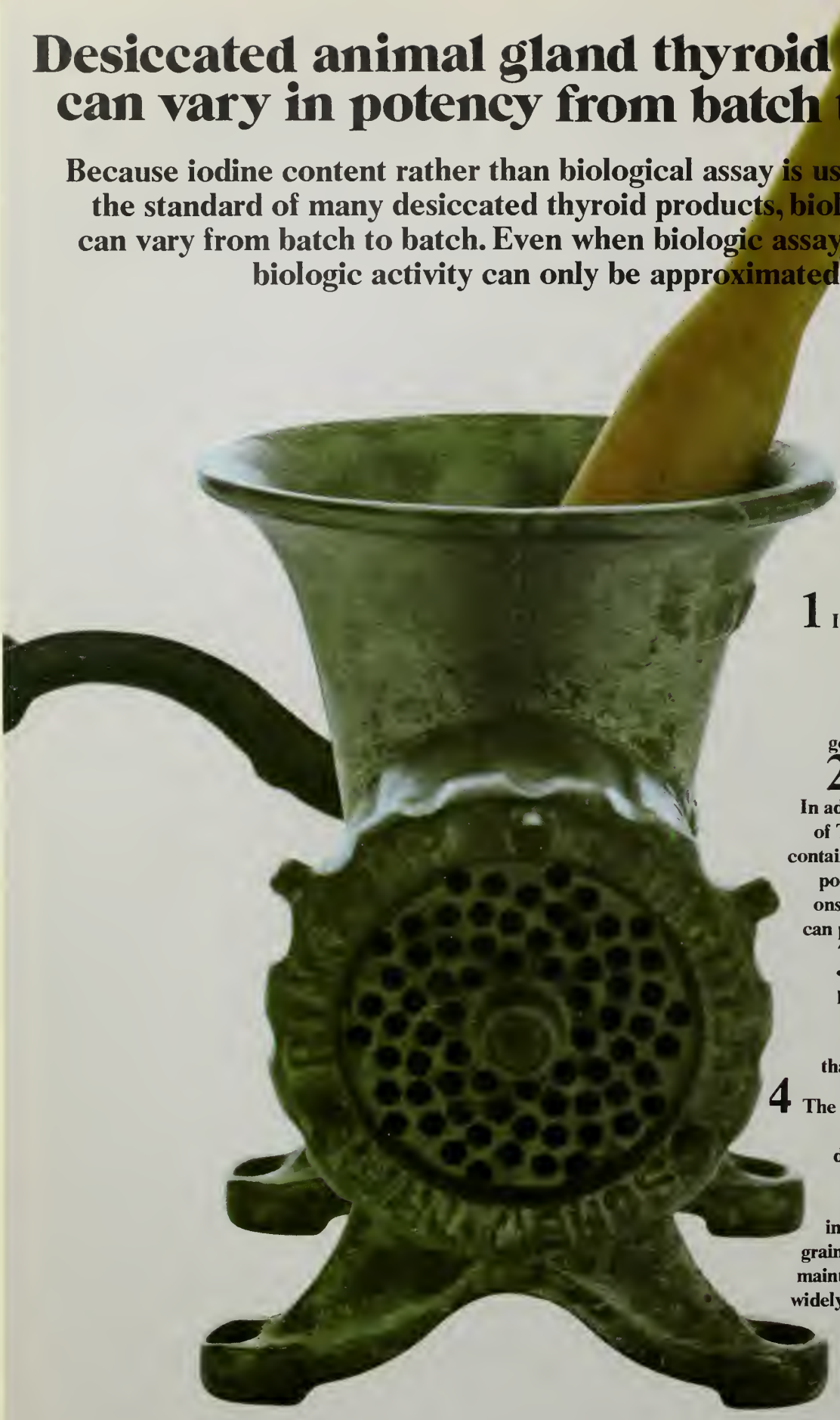
Asa M. Lehman, Philadelphia; Jefferson Medical College, 1915; age 86; died June 15, 1975. A son survives him.

Synthroid®
(sodium levothyroxine, U.S.P.) FLINT
or
desiccated thyroid

consider the differences...

Desiccated animal gland thyroid products can vary in potency from batch to batch.

Because iodine content rather than biological assay is used to measure the standard of many desiccated thyroid products, biologic activity can vary from batch to batch. Even when biologic assay is employed, biologic activity can only be approximated.



1 It is recognized that T_4 and T_3 content in desiccated thyroid and thyroglobulin varies from animal to animal, by animal species, geography, and animal diet.

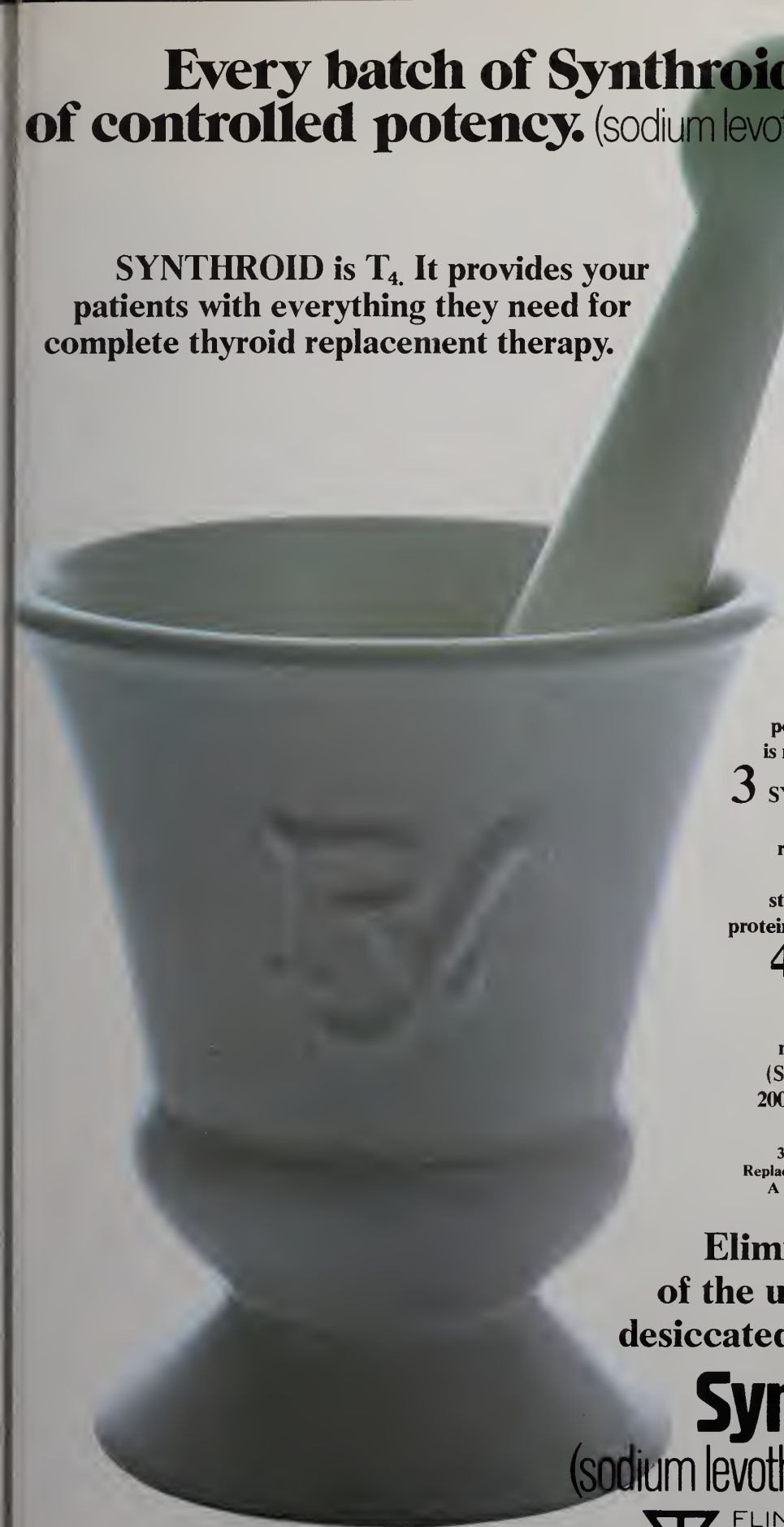
2 Of therapeutic concern: In addition to varying amounts of T_4, desiccated thyroid may contain varying amounts of T_3, a potent compound with rapid onset and fleeting action that can produce metabolic surges.

3 Even when kept under proper storage conditions, desiccated thyroid deteriorates more rapidly than the synthetic hormone.

4 The "usual maintenance dose" for the widely prescribed desiccated thyroid is "from 1 grain to 3 grains per day, but it may vary, in individual patients from 1/2 grain to 10 grains."[1] The "usual maintenance dose" of the most widely prescribed thyroglobulin (which is also a desiccated thyroid product) is "0.5 to 3.0 grains daily."[2]

1. Armour Thyroid (Tablets). 1975 Physicians' Desk Reference. p. 561.
2. Proloid® (thyroglobulin). 1975 Physicians' Desk Reference. p. 1575.

Every batch of Synthroid® T_4 is of controlled potency. (sodium levothyroxine, U.S.P.) FLINT



SYNTHROID is T_4. It provides your patients with everything they need for complete thyroid replacement therapy.

1 Sodium levothyroxine is *not derived* from any animal gland source. It is a synthetic and, since sodium levothyroxine is the only active ingredient, its weight is the sole determinate of potency.

2 SYNTHROID (sodium levothyroxine) is T_4 which is converted by the patient to T_3 at the cellular level, thereby providing a physiologic source and amount of T_3 to meet metabolic needs for complete thyroid replacement therapy. Because the onset of effect is slower and more steady, the possibility of sudden metabolic surges is reduced with SYNTHROID therapy.

3 SYNTHROID (sodium levothyroxine) products have a longer and more reliable shelf life than Thyroid U.S.P. when kept under the same proper storage conditions. There is no animal protein present in SYNTHROID products.

4 A recent study of 44 patients with hypothyroidism indicates that 89 percent of the patients were maintained with doses of L-thyroxine (SYNTHROID) between 100 mcg. and 200 mcg. (0.1 mg. and 0.2 mg.) per day.[3]

3. Stock, J.M., Surks, M.I., and Oppenheimer, J.H.: Replacement dosage of L-thyroxine in hypothyroidism. A re-evaluation. New Engl. J. Med. *290*:529-33, 1974.

Eliminates many of the uncertainties of desiccated thyroid therapy.

Synthroid®
(sodium levothyroxine, U.S.P.) FLINT

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

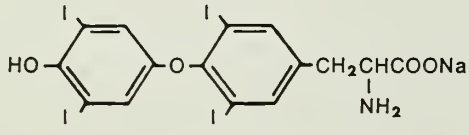
See reverse side for full prescribing information.

Synthroid®
(sodium levothyroxine, U.S.P.*) FLINT

Synthroid Tablets—for oral administration
Synthroid for Injection—for parenteral administration

Description

SYNTHROID (sodium levothyroxine) **Tablets** and SYNTHROID **Injection** contain synthetic crystalline sodium levothyroxine (L-thyroxine). L-thyroxine is the principal hormone secreted by the normal thyroid gland.



Sodium Levothyroxine

Actions

SYNTHROID (sodium levothyroxine) **Tablets**, taken orally, provide hormone that is readily absorbed from the gastrointestinal tract. SYNTHROID **Injection** is effective by any parenteral route. Following absorption, the synthetic L-thyroxine provided by SYNTHROID products cannot be distinguished from L-thyroxine that is endogenously secreted. Each is bound to the same serum proteins and each exhibits a six to seven day circulating half-life in the euthyroid individual.

Both SYNTHROID products will provide L-thyroxine as a substrate for physiologic deiodination to L-triiodothyronine. Therefore, patients taking SYNTHROID products will demonstrate normal blood levels of L-triiodothyronine even when the thyroid gland has been surgically removed or destroyed by radioiodine. Administration of levothyroxine alone will result in complete physiologic thyroid replacement.

Indications

SYNTHROID (sodium levothyroxine) products serve as specific replacement therapy for reduced or absent thyroid function of any etiology. SYNTHROID **Injection** can be used intravenously whenever a rapid onset of effect is critical, and either intravenously or intramuscularly in hypothyroid patients whenever the oral route is precluded for long periods of time.

Contraindications

There are no absolute contraindications to SYNTHROID (sodium levothyroxine) therapy. Relative contraindications include acute myocardial infarction, uncorrected adrenal insufficiency and thyrotoxicosis. (See WARNINGS)

Warnings

Patients with cardiovascular diseases warrant particularly close attention during the restoration of normal thyroid function by any thyroid drug. In such cases, low initial dosage increased slowly by small increments is indicated. Occasionally, the cardiovascular capacity of the patient is so compromised that the metabolic demands of the normal thyroid state cannot be met. Clinical judgment will then dictate either a less-than-complete restoration of thyroid status or reduction in thyroid dosage.

Endocrine disorders such as diabetes mellitus, adrenal insufficiency (Addison's disease), hypopituitarism and diabetes insipidus are characterized by signs and symptoms which may be diminished in severity or obscured by hypothyroidism. SYNTHROID (sodium levothyroxine) therapy for such patients may aggravate the intensity of previously obscured symptoms and require appropriate adjustment of therapeutic measures directed at these concomitant disorders.

Thyroid replacement may potentiate the effects of anticoagulants. Patients on anticoagulant therapy should have frequent prothrombin determinations when instituting thyroid replacement to gauge the need to reduce anticoagulant dosage.

Precautions

Overdosage with any thyroid drug may produce the signs and symptoms of thyrotoxicosis, but resistance to such factitious thyrotoxicosis is the general rule. With SYNTHROID (sodium levothyroxine) **Tablets**, the relatively slow onset of action minimizes the risk of overdose but close observation in the weeks following institution of a dosage regimen is advised. Treatment of thyroid hyperactivity induced by oral medication is confined to interruption of therapy for a week, followed by reinstitution of daily therapy at an appropriately reduced dosage.

Adverse reactions

Adverse reactions are due to overdose and are those of induced hyperthyroidism.

Dosage and administration

For most adults, a final dosage of 100 mcg (0.1 mg) to 200 mcg (0.2 mg) of SYNTHROID (sodium levothyroxine) **Tablets** daily will restore normal thyroid function and only occasionally will patients require larger doses. Failure to respond adequately to a daily oral intake of 400 mcg (0.4 mg) or more is rare and should prompt reconsideration of the diagnosis of hypothyroidism, special investigation of the patient in terms of malabsorption of L-thyroxine from the gastrointestinal tract or poor adherence to therapy.

The concomitant appearance of other diseases, especially cardiovascular diseases, usually dictates a replacement regimen with initial doses smaller than 100 mcg/day (0.1 mg).

In otherwise healthy adults with relatively recent onset of hypothyroidism, full replacement dose of 150 mcg (0.15 mg) or 200 mcg (0.2 mg) has been instituted immediately without untoward effect and with good therapeutic response. General experience, however, favors a more cautious approach in view of the possible presence of subclinical disorders of the cardiovascular system or endocrinopathies.

The age and general physical condition of the patient as well as the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage. In the elderly patient with long standing disease, evidence of myxedematous infiltration and symptomatic, functional or electrocardiographic evidence of cardiovascular dysfunction, the starting dose may be as little as 25 mcg (0.025 mg) per day. Further incremental increases of 25 mcg (0.025 mg) per day may be instituted at three to four week intervals depending on patient response. Conversely, otherwise healthy adults may be started at higher daily dosage and raised to the full replacement dosage in two to three weeks. Clearly it is the physician's judgment of the severity of the disease and close observation of patient response which determines the rate of dosage titration.

Laboratory tests to monitor thyroid replacement therapy are of limited value. Although measurement of normal blood levels of thyroxine in patients on replacement regimens frequently coincides with the clinical impression of normal thyroid status, higher than normal levels on oral replacement of levothyroxine occasionally occurs and should not be considered evidence of overdosage per se.

In all cases, clinical impression of the well-being of the patient takes precedence over laboratory determination in determining the appropriate individual dosage.

In infants and children, there is a great urgency to achieve full thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult, as much as 300 mcg (0.3 mg) to 400 mcg (0.4 mg) per day.

In myxedema coma or stupor, without concomitant severe heart disease, 200 to 500 mcg of SYNTHROID **Injection** may be administered intravenously as a solution containing 100 mcg/ml. Although the patient may show evidence of increased responsivity within six to eight hours, full therapeutic effect may not be evident until the following day. An additional 100 to 300 mcg or more may be given on the second day if evidence of significant and progressive improvement has not occurred. Like the oral dosage form, SYNTHROID **Injection** produces a predictable increase in the circulating level of hormone with a long half-time. This usually precludes the need for multiple injections but continued daily administration of lesser amounts intravenously should be maintained until the patient is fully capable of accepting a daily oral dose.

In the presence of concomitant heart disease, the sudden administration of such large doses of L-thyroxine intravenously is clearly not without its cardiovascular risks. Under such circumstances, intravenous therapy should not be undertaken without weighing the alternative risks of the myxedema coma and the cardiovascular disease. Clinical judgment in this situation may dictate smaller intravenous doses of levothyroxine.

SYNTHROID **Injection** by intravenous or intramuscular routes can be substituted for the oral dosage form when ingestion of SYNTHROID **Tablets** is precluded for long periods of time.

How supplied

SYNTHROID (sodium levothyroxine) **Tablets** are supplied as scored, color-coded compressed tablets in 6 concentrations: 25 mcg (0.025 mg)—orange . . . 50 mcg (0.05 mg)—white . . . 100 mcg (0.1 mg)—yellow . . . 150 mcg (0.15 mg)—violet . . . 200 mcg (0.2 mg)—pink . . . 300 mcg (0.3 mg)—green. Depending on strength, these tablets are available in bottles of 100, 500, 1000 and 5000.

SYNTHROID (sodium levothyroxine) for **Injection** is supplied in 10 ml vials containing 500 mcg of lyophilized active ingredient and 10 mg of Mannitol, U.S.P. A separate 5 ml vial containing Sodium Chloride Injection, U.S.P. is provided as a diluent.

Directions for reconstitution

Reconstitute the lyophilized sodium levothyroxine by aseptically adding 5 ml of the Sodium Chloride Injection, U.S.P. to the vial. Shake vial to insure complete mixing. **Use immediately** after reconstitution. Discard any unused portion.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

*U.S. Pat. 2,889,363

Spasm reactor?

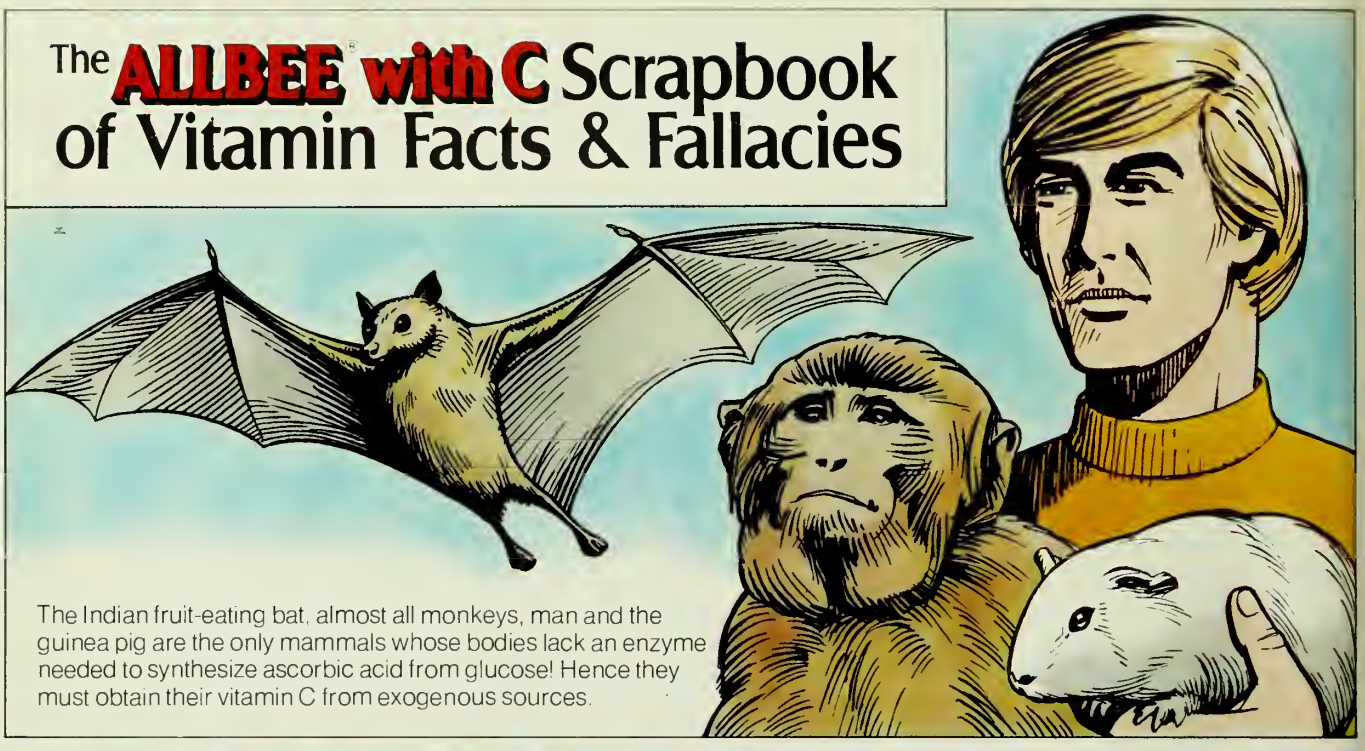
Donnatal®!

	each tablet, capsule or 5 cc. teaspoonful of elixir (23% alcohol)	each Donnatal No. 2	each Extentab
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital (warning: may be habit forming)	(¼ gr.) 16.2 mg	(½ gr.) 32.4 mg	(¾ gr.) 48.6 mg.

Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients.

A·H·ROBINS A H Robins Company, Richmond, Virginia 23220

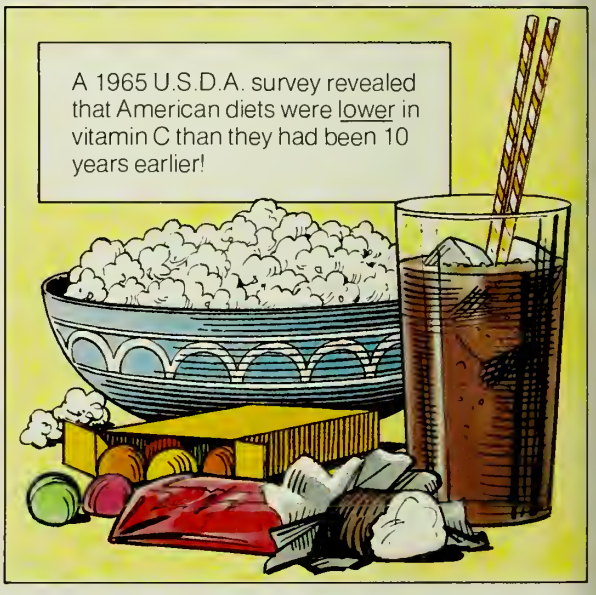
The ALLBEE® with C Scrapbook of Vitamin Facts & Fallacies



The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.

De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food." The disease he described was probably scurvy.

A 1965 U.S.D.A. survey revealed that American diets were lower in vitamin C than they had been 10 years earlier!



The outer leaves of cabbage and brussels sprouts contain more vitamin C than the heads. Yet, ironically, these are often trimmed away by the grocer to improve appearance and enhance sales appeal! Many housewives trim them even more before cooking!

Available on your prescription or recommendation

ALLBEE® with C

High Potency B-Complex and Vitamin C Formula

A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

Pennsylvania Guide to Continuing Medical Education

prepared by: PENNSYLVANIA MEDICAL
Continuing Education Institute
20 Erford Road Lemoyne, Pennsylvania 17043
(717) 238-1635

This list of continuing medical education announcements is published as a supplement to the September and January issues of PENNSYLVANIA MEDICINE. It includes all intermittent programs, courses, seminars, lectures, and other continuing medical education activities that were reported prior to the deadline. Items received after the deadline will be published (if presentation date has not passed) in the next supplement. For a reprint of this supplement or for submitting additional announcements, contact the Pennsylvania Medical Continuing Education Institute at the address shown above.

In most cases, each of the continuing medical education activities listed in this supplement has been granted AAFP and ACGP (osteopathic) credit. Contact those offices for details.

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General Abbreviations:

		Gen	General
		Grad	Graduate
Acad	Academy	Hosp	Hospital
Admin	Administrator	Inst	Institute
Amer	American	Lab(s)	Laboratory, Laboratories
Assn	Association	Med	Medical, Medicine
Ave(s)	Avenues(s)	Mem	Memorial
Bd	Board	Natl	National
Blvd	Boulevard	N	North
Bldg	Building	Pkwy	Parkway
Cntr	Center	Phys	Physicians
Chrm	Chairman	Pa	Pennsylvania
Clin	Clinic, Clinical	Box	Post Office Box
Co	County	Prac	Practice
Coll	College	Prof	Professional
Comm	Committee	Prgm	Program
Cmsn	Commission	RMP	Regional Medical Program
Cont	Continuing	Rehab	Rehabilitation
CME	Continuing Medical Education	Rd	Road
		Rm	Room
Dept	Department	Sch	School
Dir	Director	Secy	Secretary
DME	Director Medical Education	Serv	Service
		Soc	Society
Dist	District	S	South
Div	Division	St	State, Street, Saint
Dr	Drive	Surg(s)	Surgeons(s)
E	East	Univ	University
Educ	Education	VA	Veterans Administration
Exec	Executive	W	West

REFERENCE CODE FOR ACCREDITED PENNSYLVANIA INSTITUTIONS
(Each of the following institutions has continuing medical education accreditation to grant Category One credit.)

Note: When any of these names appear in individual announcements, the code name (rather than full name) is printed. Refer to this section for address.

ACP—Amer. Coll. of Phys., 4200 Pine St., Philadelphia 19104
ACS—Amer. Coll. of Surgs., 55 E. Erie St., Chicago, Ill. 60611
AHA—Amer. Heart Assn., Pa. Affiliate, P.O. Box 2435, Harrisburg 17105
Allegheny—Allegheny Gen. Hosp., 320 E. North Ave., Pittsburgh 15212
Allergy—Pa. Allergy Assoc., 240 N. 36th St., Camp Hill 17011
AMA—Amer. Med. Assn., 535 N. Dearborn St., Chicago, Ill. 60610
Anesthesiologists–Pa. Soc. of Anesthesiologists, 20 Erford Rd., Lemoyne, 17043
Chester—Chester Co. Hosp., 602 E. Marshall St., West Chester 19380 (% Joseph L. Abbott, M.D.)
Clin. Path.—Pa. Assn. of Clin. Path., 1735 W. Main St., Norristown 19401
Clin. Sch.—Clin. Sch. of the Family Inst., Wurzel Bldg., Philadelphia Psychiatric Cntr., Ford Rd. and Monument Ave., Philadelphia 19131
Coatesville VA—Coatesville Vet. Admin. Hosp., Coatesville 19320
Coll. Phys./Phila.—Coll. of Phys. of Philadelphia, 19 S. 22nd St., Philadelphia 19103
Colon and Rectal—Pa. Soc. of Colon and Rectal Surg., Liberty Sq. Med. Cntr., 17th and Liberty Sts., Allentown 18104
Conemaugh—Conemaugh Valley Memorial Hosp., 1086 Franklin St., Johnstown 15905
Delaware Co.—Delaware Co. Mem. Hosp., Lansdowne Ave., Drexel Hill 19026
Dermatology—Pa. Acad. of Dermatology, 8220 Castor Ave., Philadelphia 19152 (% Charles H. Greenbaum, M.D.)
Elwyn—Elwyn Institute, 111 Elwyn Rd., Elwyn 19063
EPPI—Eastern Pa. Psychiatric Institute, Henry Ave. and Abbottsford Rd., Philadelphia 19129
Erie PG—Erie Postgraduate Med. Inst., Gannon Coll., Erie 16501
Frankford—Frankford Hosp., Frankford Ave. and Wakeling St., Philadelphia 19124
Geisinger—Geisinger Med. Cntr., Danville 17821
Hahnemann—Hahnemann Med. Coll., 230 N. Broad St., Philadelphia 19102
Hamot—Hamot Med. Cntr., Erie 16512
Harrisburg—Harrisburg Hosp., Harrisburg 17101
M. S. Hershey—Pa. State Univ. Coll. of Med., M. S. Hershey Med. Cntr., Univ. Dr., Hershey 17033
Institute—Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139
Jeanes—Jeanes Hosp. of Fox Chase Center for Cancer and Med. Sciences, 7600 Central Ave., Philadelphia 19111
Jefferson—Jefferson Med. Coll. 1025 Walnut St., Philadelphia 19107
Lackawanna Co.—Lackawanna Co. Med. Soc., Med. Arts Bldg., 327 N. Washington Ave., Scranton 18503
Lebanon VA—Lebanon Vet. Admin. Hosp., Lebanon 17042
Lehigh AHEC—Lehigh Valley Area Health Ed. Cntr. 335 N. Eighth St., Allentown 18102
MCP—Med. Coll. of Pa., 3300 Henry Ave., Philadelphia 19129
Mercy/Pgh.—Mercy Hosp., Pride & Locust Sts., Pittsburgh 15219
Norristown State—Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19141
Packer—Robert Packer Hosp., Sayre 18840
PAFP—Pa. Acad. of Family Phys., 5600 Derry St., Harrisburg 17111
Paoli—Paoli Mem. Hosp., Paoli 19301
PAO&O—Pa. Acad. of Oph. & Otol., 1248 Hamilton St., Allentown 18102
PMS—Pa. Med. Society, 20 Erford Rd., Lemoyne 17043
Phoenixville—Phoenixville Hosp., 140 Nutt Rd., Phoenixville 19460
Polyclinic—Harrisburg Polyclinic Hosp., Third St. and Polyclinic Ave., Harrisburg 17105
Psychiatry—Pa. Psychiatric Soc. 20 Erford Rd., Lemoyne 17043
Radiology—Pa. Radiological Soc., 20 Erford Rd., Lemoyne 17043
Reading—Reading Hosp., 6th Ave. & Spruce St., Reading 19602
St. Francis—St. Francis Gen. Hosp., Penn Ave. and 45th St., Pittsburgh 15201
St. Margaret—St. Margaret Mem. Hosp., 265-46th St., Pittsburgh 15201
St. Vincent—St. Vincent Hosp., Erie 16512
Temple—Temple Univ. Health Sciences Cntr., 3400 N. Broad St., Philadelphia 19140
U. of Pa.—Univ. of Pa. Sch. of Med., 288 Med. Labs. Bldg., Philadelphia 19174
Pitt—Univ. of Pittsburgh Sch. of Med., 1022-H Scaife Hall, Pittsburgh 15261
Roentgen Ray—Phila. Roentgen Ray Soc., Temple U. Health Sciences Cntr., Philadelphia 19140
Warren State—Warren St., Hosp., Box 249, Warren 16365
Washington—Washington Hosp., 155 Wilson Ave., Washington 15301
West Penn—Western Pa. Hosp., 4800 Friendship Ave., Pittsburgh 15224
York—York Hosp., George St. & Rathton Rd., York 17405

ANNOUNCEMENTS

For more information, such as: frequency of sessions, fees, maximum registration, faculty, etc., contact the director at the address given in the announcement or in the REFERENCE CODE box on the cover:

Abington; Abington Mem. Hosp. '75-'76 Academic Year
(1) Grand Rounds; by **Temple**; second and fourth Tuesdays, Sept. 9-May 25 (76-1-32)
Contact George R. Green, M.D., Chrm., Med. Educ. and Prgm. Comm., Abington Mem. Hosp., Abington 19001

Allentown and Sacred Heart Hosp.; '75-'76 Academic Year
(1) Cont. Educ. in Anesthesiology; by **Anesthesiologists**; Wednesdays, Sept. 3, 1975-Aug. 25 1976 (76-1-22)
Contact Samuel M. Lerner, M.D., Chief of Anesthesiology, ASHH, 1200 S. Cedar Crest Blvd., Allentown 18105

Allentown-Sacred Heart Hosp.; '75-'76 Academic Year
(1) Continuing Medical Education Program; by **U. of Pa.**; second and fourth Wed., Sept 10-June 9 (76-1-34)
Contact Fred Fister, M.D., Allentown-Sacred Heart Hosp., Fourth and Chew Sts., Allentown 18102

Aliquippa; Aliquippa Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; alternately at Aliquippa and Beaver; monthly, Sept.-May (76-1-33)
Contact Mrs. Susan Frey, Exec. Sec., Beaver Co. Med. Soc., 350 Adams St., Rochester 15074

Altoona, Altoona Hosp., '75-76 Academic Year
(1) Medical Seminar; by **M.S. Hershey**, dates to be announced (76-1-301)
Contact Ray Snyder, Dir. Cont. Med Educ., **M.S. Hershey.**

Beaver; Beaver Co. Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; alternately at Beaver and Aliquippa; monthly; Sept.-May (76-1-33)
Contact Mrs. Susan Frey, Exec. Secy., Beaver Co. Med. Soc., 350 Adams St., Rochester 15074

Bedford Springs; PAO&O; Annual Meeting
(1) Scientific Program; May 19-22, 1976; at Bedford Springs Hotel (76-1-417)
Contact Robert E. Shoemaker, M.D., Chrm., Scientific Work, **PAO&O**

Bethlehem; **Lehigh AHEC;** Nov. 15, 1975
(1) Clinical Concepts of Shock; by **Lehigh AHEC** and Lehigh Valley TB and Health Assoc.; at Holiday Inn East (75-2-40)
Contact Joseph E. Vincent, M.D., **Lehigh AHEC**

Bethlehem; St. Luke's Hosp.; '75-'76 Academic Year
(1) Continuing Medical Education at Community Hospitals; by **MCP**; monthly, July-June (76-1-298)
Contact Gerald H. Escovitz, M.D., Associate Dean, **MCP**

Bradford, McKean Co. Med. Soc.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**, at Penn Hills Country Club; monthly, Sept. 16-June 22 (76-1-416)
Contact Thomas Logio, M.D., Chrm., Program Comm., McKean Co. Med. Soc., 2 Thompson Park, Kane 16735

Bridgeville; Mayview St. Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**; second Tues. Sept. 9-Jan. 13 (76-1-12)
Contact Robert Trivus, M.D., Superintendent, Mayview St. Hosp., Bridgeville 15017

Bryn Mawr; Bryn Mawr Hosp.; '75-'76 Academic Year
(1) Tumor Board; by **Jefferson**; Fridays, Sept. 1-Aug. 31 (76-1-35)
(1) Correlated Clinical Science Course-Pediatric; by **Jefferson**; monthly, Oct. 21-May 18 (76-1-36)
(1) Correlated Clinical Science Course-Medicine; by **Jefferson**; monthly, Sept. 18-May 20 (76-1-39)
(1) Correlated Clinical Science Course-Psychiatry; by **Jefferson**, monthly, Oct.-June (76-1-37)
(1) Correlated Clinical Science Course-Surgery; by **Jefferson**; monthly, Sept. 19-June 18 (76-1-38)
Contact Theo. J. Berry, M.D., DME, Bryn Mawr Hosp., Bryn Mawr 19010
(1) Interdepartmental Clinical Conference; by **Jefferson**; monthly, Sept.-June (76-1-290)
Contact Dieter E. Peltz, M.D., Bryn Mawr Hosp., Bryn Mawr 19010

Butler; Butler Co. Med. Soc.; '75-'76 Academic year
(1) Continuing Education for Physicians; by **Pitt**, monthly, Sept.-April (76-1-40)
Contact S.A. Nallathambi, M.D., Butler 16001

Canonsburg; Canonsburg Gen. Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**, monthly, Oct. 7-May 4; (76-1-41)
Contact Louis Signorella, M.D., Canonsburg Gen. Hosp., Canonsburg 15317

Carnegie; Woodville St. Hosp.; 1975
(1) Continuous Education Seminar; by **Pitt**; every Tuesday, Feb. 4-Nov. 4 (75-2-1)
Contact Maurice S. Cerul, M.D., Div. of Educ., Woodville St. Hosp., Carnegie 15106

Chambersburg; Chambersburg Hosp.; '75-'76 Academic Year
(1) Medical Seminar; by **M.S. Hershey**, dates to be announced (76-1-303)
Contact: Ray Snyder, Dir. Cont. Med. Educ., **M.S. Hershey.**

Charleroi; Monongahela Valley Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**; alternately at Charleroi and Monongahela; monthly, Sept. 16-Mar.16 (76-1-42)
Contact: U.A. DeRienzo, M.D., Charleroi Div., Monongahela Valley Hosp., Inc., Charleroi 15022

Chester; Crozer-Chester Med. Cntr.; '75-'76 Academic Year
(1) Continuing Education Program; by **Hahnemann**; weekly, Sept. 9-May 25 (76-1-43)
Contact: Robert J. Schaefer, Ex. Dir., Cont. Educ., **Hahnemann**

Coatesville; **Coatesville VA**; 1975
(1) Treatment Approaches and Goals in Mental Health; Oct. 15; by **Jefferson** and Chester Co. Med. Soc. (75-2-33)
Contact: J. Clifford Scott, M.D., Dir. of Prof. Educ., **Coatesville VA**

Danville; **Geisinger;** '75-'76 Academic Year
(1) Rheumatoid Arthritis and Diagnosis and Treatment for the Practitioner; Sept. 17 (75-2-34)
(1) Altered States of Consciousness; Oct. 1 (75-2-35)
(1) Seminar on Emergency Medicine; Oct. 15 (75-2-36)
(1) Clinical Immunology Tests: Interpretations and Correlations; Oct. 24 (75-2-37)
(1) Diagnosis and Management of Common Pulmonary Problems; Nov. 12 (75-2-38)
(1) Advances in Clinical Practice—1976; Feb. 14-15; at Sheraton Inn (76-1-15)
(1) Management of Diabetic Complications; Mar. 17 (76-1-16)
(1) Allergy Immunology for the Practitioner; Mar. 31 (76-1-17)
(1) Practical Dermatology and New Problems in Dermatology; Apr. 7 (76-1-18)
(1) 8th Annual Conference Devoted to the Special Child; May 1 (76-1-19)
(1) Diagnosis and Treatment of Thyrotoxicosis; May 5 (76-1-20)
(1) Syncope and Pacemaker; May 19 (76-1-21)
Contact: Mildred K. Fleetwood, Ph.D., Chairperson, Educ. Comm., **Geisinger**

Easton; Easton Hosp.; '75-'76 Academic Year
(1) Continuing Education Program; by **Hahnemann**; monthly-Oct., Dec., April, and June; (76-1-65)
Contact: Robert J. Schaefer, Ex. Dir., Cont. Educ., **Hahnemann**

Ephrata; Ephrata Community Hosp.; '75-'76 Academic Year
(1) Staff Conferences; by **Temple**; monthly, Sept. 19-June 18 (76-1-66)
Contact Paul Shantz, M.D., Chrm., Med. & Dental Staff, Ephrata Community Hosp., Ephrata 17522

Franklin; Franklin Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**; alternately at Franklin, Oil City, and Titusville; monthly, Oct.-June (76-1-67)
Contact: Robert M. Pilewski, M.D., Oil City Hosp., Oil City 16301

Gettysburg; Annie Warner Hosp.; 1975
(1) Current Medical Concepts; by **Polyclinic**; monthly, Sept. 25-Oct. 23 (75-2-25)
Contact: Harrison F. Harbach, M.D., 525 W. Middle St., Gettysburg 17325

Greensburg; Centralized Hosp. Service of Westmoreland Co.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**; monthly, Sept.-spring 1976 (76-1-68)
Contact: Mr. Ira Schugar, Dir. of Educ. and Training, Centralized Hosp. Service-Westmoreland Co., Greensburg 15601

Harrisburg; **Allergy**; Nov. 7, 1975
(1) Scientific Program; at Host Inn (75-2-101)
Contact: Harold Kreithen, M.D., President, Pa. Allergy Assoc., 1033 Hamilton St., Allentown 18101

Key to symbols:

( ) Numbers in parentheses at the beginning of an announcement indicate the PRA Category number in which attendance at this program should be reported. You may report each hour of attendance.

(75-1-XX) Numbers in parentheses at the end of an announcement are code numbers which will be helpful as a cross reference from the Subject Index section of this supplement.

Bold Face Type indicates an institution that has Category One accreditation. This name MUST APPEAR on your PRA APPLICATION to the AMA if you are to receive Category One credit. (See page 1 for mailing address of contact.)

arrisburg: **Colon and Rectal**; Nov. 5, 1975
(1) Scientific Prgm.; at Host Inn (75-2-26)
ontact Indru T. Khubchandani, M.D., Secy., **Colon and Rectal**

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arrisburg; **Harrisburg**, '75-'76 Academic Year
(1) Cont. Educ. Seminars; alternately at **Harrisburg** and **Polyclinic**; monthly (except ec., Jan. and March); Sept. 18-Apr. 22 (76-1-2)
ontact Thomas F. Fletcher, M.D., Dir. of Med Affairs, **Harrisburg**

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arrisburg; Internal Medicine; Nov. 7, 1975
(1) Scientific Program; by Pa. Soc. of Internal Medicine and **PMS** (75-2-128)
Contact William B. Harlan, Exec. Secy., Pa. Soc. of Internal Med., 105 Telegraph dg. Harrisburg 17101

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arrisburg; Orthopaedics; Nov. 6, 1975
(1) Scientific Program; by Pa. Orthopaedic Society and **PMS**; at Host Inn 8 hrs. 5-2-96)
ontact: Thomas K. Howard, M.D., Prgm. Chrm., Pa. Orthopaedic Soc., 316 Potomac ve. Hanover 17331

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arrisburg; **PMS**; '75-'76 Academic Year
(1) Coping With Change; Nov. 6; at Host Inn, 3½ hrs. (75-2-94)
(1) Role of Medical Director in Skilled Nursing Facility; Nov. 5; at Host Inn; 6½ hrs. 5-2-95)
(1) Doctor-Patient Communications; by Comm. on Quackery; date to be announced 6-1-291)
(1) Establishing Yourself in Medical Practice; Nov. 18-19, at Penn Harris Motor Inn 5-2-99)
(1) Principles of Medical Practice Management, April 30-May 1; location to be announced (76-1-292)
ontact LeRoy C. Erickson, Dir. of Educ. Activities, Cncl. on Educ. & Science, **PMS**

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arrisburg; Physical Medicine and Rehabilitation; Nov. 7, 1975
1) Diabetic Complications Encountered in Rehabilitation; by Pa. Acad. of Physical ed. and Rehabilitation and **PMS**; at Host Inn; 2 hrs. (75-2-97)
ontact: Leon Reinstein, M.D., Dept. of Rehabilitation Med., Thomas Jefferson Hosp., hiladelphia 19107

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arrisburg; Plastic Surgery; Nov. 6, 1975
1) Scientific Program; by Robert H. Ivy Soc. and **PMS;** at Host Inn (75-2-103)
ontact: F.M. Tooze, M.D., 210 W. 6th St., Erie 16507

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arrisburg; **Polyclinic**; '75-'76 Academic Year
1) Cont. Educ. Seminars; alternately at **Harrisburg** and **Polyclinic**; monthly (except c. Jan. and March); Sept. 18-Apr. 22 (76-1-2)
ntact: David A. Smith, M.D., Med. Dir., **Polyclinic**

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rrisburg; **Psychiatry**; Nov. 7, 1975
1) Use and Abuse of Psychotropic Chemicals; at Host Inn; 3 hrs. (75-2-98)
ntact: Donald N. McCoy, Exec. Sec., **Psychiatry**

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rrisburg; **Surgery**; Nov. 7, 1975
1) Scientific Program; by Central Pa. Chapt., Amer. Coll. of Surgeons and **PMS**, at st Inn (75-2-102)
ntact: David Nahrwold, M.D., Sec.-Treas., Central Pa. Chapt., ACS, **M.S. Hershey.**

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zleton: Hazleton St. Gen. Hosp.; '75-'76 Academic Year
1) Seminars in Continuing Medical Education; by **U. of Pa.**, St. Joseph Hosp. and zleton Branch of Luzerne Co. Med. Soc.; Thursday, Sept. 18-May 30 (76-1-4)
ntact Robert Gunderson, M.D., Hazleton St. Gen. Hosp., Suite 412-Northeastern dg., Hazleton 18201

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shey: **AHA**, Sept. 12-13, 1975
1) Heart Failure and Heart Murmurs; at Hershey Motor Lodge and Convention Cntr. 5-2-127)
ntact: Local Heart Chapter or **AHA**

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shey: **Dermatology**, Sept. 19-21, 1975
1) Advances in Dermatology: 1975; by **Dermatology**, at Hotel Hershey (75-2-2)
ntact: Charles H. Greenbaum, M.D., Secy., **Dermatology**

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shey: **M.S. Hershey**; '75-'76 Academic Year
1) Child Abuse; by **ACS** and Amer. Trauma Soc.; at Hershey Motor Lodge; Sept. 9-10 2-28)
ntact W.E. DeMuth, M.D., **M.S. Hershey**
1) Anesthesia Visiting Professor Series; monthly (76-1-304)
1) Anesthesiology: Case Discussion; Tuesdays (76-1-305)
1) Anesthesia Seminar; Wednesdays (76-1-306)
1) Current Concepts in Family Medicine; Tuesdays (76-1-310)
1) Clinical Pharmacology Grand Rounds; First and Third Mondays (76-1-313)
1) Clinical Nutrition Symposium; Sept. 20 (75-2-104)
1) Basic Electrocardiography; Sept. 24-26 (75-2-105)
(1) Emergency Medicine Symposium; monthly (76-1-315)
(1) Advanced Workshop for Career Emergency Physicians; Oct. 20-24 (75-2-106)
(1) Endocrinology and Reproductive Biology; Wednesdays (76-1-314)
(1) Masters & Johnson discussing "Rapid Treatment of Sexual Dysfunction"; Oct. 9, 1975 (75-2-92)
(1) Family Medicine Refresher Course (preparatory for Family Medicine National Board Examinations); Sept. 8-12 (75-2-107)
(1) Alone, Abandoned and Afraid, Nov. 15 (75-2-109)
(1) Medicine Grand Rounds; Thursdays (76-1-316)
(1) Nervous System Seminar; monthly (76-1-317)
(1) Evenings in Cardiology; First Wednesdays each month (76-1-318)
(1) Multidisciplinary Tumor Conference; Second and Fourth Wednesdays (76-1-319)
(1) Communications for Health Care Personnel; Sept. 15-Nov. 17—four sessions (75-2-112)
(1) Quality Control of Nuclear Medicine; Sept. 18 (75-2-113)
(1) OB/GYN Grand Rounds; Fridays (76-1-321)
(1) Advances in Management of Fetus and Newborn; by Pa. Chapt. of Amer. Acad. of Pediatrics; at Hotel Hershey (75-2-111)
(1) New Methods of Cancer Treatment, Dec. 12 (75-2-110)
(1) Gynecologic Oncology Seminar, Nov. 13-15 (75-2-108)
(1) Tri-County Pathology Soc.; monthly (76-1-322)
(1) Pediatric Grand Rounds; Thursdays (76-1-323)
(1) Psychiatry Grand Rounds; First and Third Thursdays (76-1-324)
(1) Psychosomatic-Consultation Conference; Thursdays (76-1-325)
(1) Child Psychiatry Conference; Fridays (76-1-326)
(1) Orthopaedic Surgery Grand Rounds; First Thursdays (76-1-327)
(1) Uroradiology Grand Rounds; Thursdays (76-1-329)
(1) Radiology Grand Rounds; First and Third Thursdays (76-1-330)
(1) Surgical Grand Rounds; Thursdays (76-1-328)
(1) Urology, Nephrology, Radiology Conference; First Wednesdays (76-1-320)
Contact Ray Snyder, Dir., Cont. Med. Educ., **M.S. Hershey**

Johnstown; Lee Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**; Sept. 16-Jan. 20 and March 16 (76-1-70)
Contact: Stephen T. Bush, M.D., Lee Hosp., Johnstown 15901

Kittanning; Armstrong Co. Med. Soc.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**; monthly, Sept.-May (76-1-72)
Contact: Roderick R. McLeod, M.D., Box 150, Kittanning 16201

Kittanning; Armstrong Co Mem. Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt;** bi-monthly, Oct.-June (76-1-73)
Contact: Roderick R. McLeod, M.D., Box 150, Kittanning, 16201

Kingston; Nesbitt Mem. Hosp.; '75-'76 Academic Year
(1) Continuing Medical Education Program; by **Geisinger**; second Thurs. Sept. 11-May 13 (76-1-71)
Contact: George B. Davis, M.D., Nesbitt Mem. Hosp., Wyoming Ave., Kingston 18704

Lancaster; Lancaster Gen. Hosp.; '75-'76 Academic Year
(1) Medical Grand Rounds; by **Temple**; weekly, July 11-June (76-1-74)
(1) Clinical Correlation in Family Med.; by **Temple**; bi-weekly, July 3-June (76-1-75)
(1) Program in Continuing Med. Educ.; by **Temple**; weekly, July 8-June (76-1-76)
(1) Scientific Program-Monthly Staff Meeting; by **Temple**; monthly, Sept. 17-June (76-1-77)
Contact: John H. Esbenshade, Jr., M.D., DME, Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17604

Lancaster; Lancaster Osteopathic Hosp.; '75-'76 Academic Year
(1) Continuing Education Program; by **Hahnemann**, weekly, Oct. 2-Feb. 5 (76-1-78)
Contact: Robert J. Schaefer, Ex. Dir. Cont. Educ., **Hahnemann**

Lansdale; North Penn Hosp.; '75-'76 Academic Year
(1) Continuing Education Program; by **U. of Pa.**; monthly, Sept. 24-June 23 (76-1-79)
Contact: Martha E. Ross, M.D., North Penn Hosp., 7th and Broad St., Lansdale 19446

Lansdale; **PAO&O**; Feb.-Dec. 1975
(1) Ophthalmic Reviews; by **PAO&O**, at Inter-County Ophthalmologic Soc. (75-2-3)
Contact: Paul Carmichael, M.D., 1000 N. Broad St., Lansdale 19446

Latrobe; Latrobe Area Hosp.; '75-'76 Academic Year
(1) Postgraduate Seminars for Physicians; by **Jefferson**; first Wednesdays, Sept.-Aug. (76-1-297)
Contact: John R. Mazero, M.D., DME, Latrobe Area Hosp., Latrobe 15650

McKeesport; McKeesport Hosp.; 1975
(1) Continuing Education for Physicians; by **Pitt**; weekly, Oct. 3-Nov. 21 (75-2-41)
Contact: Rudolph L. Buck, M.D., Chrm., Med. Educ., McKeesport Hosp., McKeesport 15132

Meadowbrook; Holy Redeemer Hosp.; '75-'76 Academic Year
(1) Continuing Educ. Prgm.; by **Hahnemann** and **Jefferson**; Sept. 24-May 27 (76-1-14)

Contact: W.F. Warrender, M.D., Chrm., Educ. Comm., Holy Redeemer Hosp., 1648 Huntingdon Pike, Meadowbrook, 19116

Monongahela; Monongahela Valley Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**, alternately at Monongahela and Charleroi; monthly, Sept. 16-Mar. 16 (76-1-42)
Contact: H.J. Levin, M.D., Monongahela Div., Monongahela Valley Hosp. Inc., Monongahela 15063

Natrona Heights; Tri-Co. Branch Med. Soc.; 1975
(1) Continuing Education for Physicians; by **Pitt**, monthly at various locations (75-2-24)
Contact: William R. Balash, M.D., Prgm. Chrm., Tri-Co. Branch Med. Soc., Allegheny Valley Hosp., Natrona Heights 15065

New Castle; Jameson Mem. Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**, alternately at Jameson and St. Francis; monthly, Sept. 9-Apr. 13 (76-1-80)
Contact: Frank J. Altomare, M.D., St. Francis Hosp. of New Castle 16101

New Castle; Lawrence Co. Med. Soc.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**; monthly, Sept. 2-May 4 (76-1-82)
Contact: James N. Bower, M.D., Chrm., Comm. on Cont. Med. Educ., 103 S. Mercer St., New Castle 16101

New Castle; St. Francis Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**, alternately at St. Francis and Jameson; monthly, Sept. 9-April 13 (76-1-80)
Contact: Frank J. Altomare, M.D., St. Francis Hosp. of New Castle 16101
(1) Continuing Education for Physicians—Chemotherapy Program; by **Pitt**, monthly, Sept. 30-Feb. 17 (76-1-81)
Contact: William G. Gillespy, M.D., St. Francis Hosp. of New Castle, New Castle 16101

New Kensington; Citizens Gen. Hosp.; 1975
(1) Cont. Educ. for Physicians; by **Pitt**; monthly, Sept. 2-Dec. 16 (75-2-29)
Contact: Walter N. Zuck, M.D., Citizens Gen. Hosp., New Kensington 15068

Norristown; **Norristown State**; '75-'76 Academic Year
(1) Clinical Medicine for Psychiatrists; 10 sessions, Sept. 24-Apr. 21 (76-1-411)
(1) Eating Disorders—Obesity and Anorexia Nervosa; by **Arthur P.** Noyes Research Foundation, Inc.; Oct. 18 (75-2-123)
(1) Geriatric Medicine and Psychiatry; weekly, Jan. 9-Feb. 20 (76-1-412)
(1) Partial Hospitalization; weekly, Nov. 12-Dec. 10 (75-2-124)
(1) Inpatient Behavioral Therapy; weekly, Sept. 12-Oct. 6 (75-2-125)
(1) Intensive Review of Neurology; weekly, Sept. 8-Apr. 12 (76-1-413)
(1) Occupational Therapy in Psychiatry; weekly, Mar. 3-31 (76-1-414)
(1) Psychopharmacology Workshops; monthly, Sept. 5-May 7 (76-1-415)
(1) Schizophrenia—Advances in Theory and Treatment; weekly, Oct. 24-Nov. 21 (75-2-126)
Contact: John D. Pruitt, M.D., Dir., Cont. Med. Educ., **Norristown State.**

Norristown, Sacred Heart Hosp.; '75-'76 Academic Year
(1) Continuing Education Program; by **Hahnemann**, monthly, Sept. 12-May 28 (76-1-83)
Contact: Robert J. Schaefer, Ex. Dir. Cont. Educ., **Hahnemann**

Oil City; Oil City Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**, alternately at Oil City, Titusville, and Franklin; monthly, Oct.-June (76-1-67)
Contact: Robert M. Pilewski, M.D., Oil City Hosp., Oil City 16301

Paoli; **Paoli**; '75-'76 Academic Year
(1) Continuing Education Program; each Wed. except first Wed. of each month, Sept. 8-June 30 (76-1-84)
Contact: Peter N. Hillyer, M.D., Chrm. Research and Educ. Common., **Paoli**

Philadelphia; **ACP**; '75-'76 Academic Year
(1) An Electrophysiological Approach to the Diagnosis and Treatment of Cardiac Arrhythmias; by **U. of Pa.**; at Hilton of Philadelphia; Sept. 29-Oct. 2 (75-2-115)
(1) Update in Infectious Diseases; by **MCP**, at Sheraton Valley Forge Hotel; Jan. 28-30 (76-1-337)
(1) Auscultation in Its Clinical Setting; by **U. of Pa.**; at Holiday Inn—University City; Apr. 26-28 (76-1-339)
Contact: M.H. Jackson, Registrar, **ACP**

Philadelphia: Albert Einstein Med. Cntr.-Northern Div.; '75-'76 Academic Year
(1) Anesthesia Seminar; by **Temple**, three times a week, Oct. 6-May 27 (76-1-86)
(1) Basic Rheumatology Course; by **Temple**, alternate weeks, July 11-June 25 (76-1-87)
(1) Cardiac Teaching Conference; by **Temple**, weekly, Sept.-June 20 (76-1-88)
(1) Cardiovascular-Pulmonary Renal Research Seminar; by **Temple**, bi-weekly, Jan.-June 20 (76-1-89)
(1) Pulmonary Lecture Series; by **Temple**; weekly, Sept. 1-June 30 (76-1-90)
(1) G.I. Weekly Conference Series; by **Temple**; weekly, Sept. 1-May 31 (76-1-91)
(1) Kidney Transplant Conference; by **Temple**, weekly, July 1-June 30 (76-1-92)
(1) Renal Conference; by **Temple**, weekly, July 1-June 30 (76-1-93)
(1) Hematology Conference; by **Temple**; weekly, Sept. 1-June 30 (76-1-94)
(1) Infectious Disease; by **Temple**, weekly, Sept.-May (76-1-95)
(1) Medical Grand Rounds; by **Temple;** weekly, Sept. 9-June 15 (76-1-96)
(1) Basic Pathophysiology in Internal Medicine; by **Temple**, weekly, Sept 8-June 14 (76-1-97)
(1) Neuroradiology Conference; by **Temple**, weekly, July 11-June 25 (76-1-98)
(1) Neurology Grand Rounds; by **Temple**, weekly, all year long (76-2-2)
(1) Reproductive Endocrinology & Infertility; by **Temple**; 24 times, Sept. 9-May 5 (76-1-99)
(1) Obstetrics & Gynecology Grand Rounds; by **Temple**, three times a month, July 1-June 30 (76-1-100)
(1) Orthopedic Conference; by **Temple**, weekly, all year long (76-2-3)
(1) Autopsy Review Conference; by **Temple**; weekly, July 10-June 26 (76-1-101)
(1) Clinical Neuro-Pathological Correlation Conference; by **Temple**, bi-weekly, July 1-June 30 (76-1-102)
(1) Pediatric Ground Rounds; by **Temple**; weekly, July-June (76-1-103)
(1) Essentials in Pediatric Psychiatry; by **Temple**, at home of Leonardo Magran M.D.; first and third Tuesdays, Sept.-May (76-1-104)
(1) Basic Science and Clinical Concept Review; by **Temple** and Moss Rehabilitation Hosp.; weekly, July 1-May 31 (76-1-105)
(1) Prosthetics/Orthotics Conference; by **Temple** and Moss Rehabilitation Hosp. weekly, July 1-June 30 (76-1-106)
(1) Grand Rounds in Rehabilitation; by **Temple** and Moss Rehabilitation Hosp. weekly, July 1-May 31 (76-1-107)
(1) Radiology Grand Rounds; by **Temple**, weekly, Sept.-May (76-1-108)
(1) Introduction to Radiological Physics & Physics of Diagnostic Radiology; by **Temple**; two days a week, Aug. 6-Nov. 26 (75-2-42)
(1) Nuclear Medicine-Introductory Physics & Clinical Aspects; by **Temple**, weekly April-July (76-1-109)
(1) Radiation Therapy-Introductory Physics & Clinical Aspects; by **Temple**; two days a week, Dec. 1-March 31 (76-1-110)
(1) General Surgery Conference; by **Temple**, weekly, Sept. 13-June 19 (76-1-111)
(1) Surgical Departmental Conference; by **Temple**, weekly, Sept. 4-June 17 (76-1-112)
Contact: Morton S. Mandell, M.D., Chrm.-Cont. Educ. SubComm., Albert Einstein Med Cntr., York & Tabor Road, Philadelphia 19141

Philadelphia; Amer. Oncologic Hosp.; '75-'76 Academic Year
(1) Cancer Detection in Office Practice; by **Jeanes** and American Cancer Soc.; one day a week for seven weeks; repeated Sept. 3-May 26 (76-1-404)
(1) Tumor Board; by **Jeanes**; weekly, Sept. 8-Aug. 28 (76-1-406)
(1) Tumor Conference; by **Jeanes**; weekly, Sept. 8-July 26 (76-1-407)
Contact: Paul F. Engstrom, M.D., Chief, Dept. of Med., Amer. Oncologic Hosp., Central and Shelmire Ave., Philadelphia 19111

Philadelphia; **Anesthesiologists**; '75-'76 Academic Year
(1) Phila. Anesthesia Study Commissions and Guest Lectures; by Philadelphia Soc of Anesthesiologists; at Philadelphia Co. Med. Soc.; first Thursdays, Oct. 2-May 6 (76-1-24)
Contact: James C. Erickson, III, M.D., Dept. of Anesthesiology, Jefferson

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Philadelphia; **Anesthesiologists**; '75-'76 Academic Year
(1) Anesthesia for Emergency Surgery; Annual Meeting at Marriott Motor Hotel; May 14-16 (76-1-26)
Contact: James C. Erickson, III, M.D., Chrm., Cmte. on Cont. Educ., **Anesthesiologists**

Philadelphia; Children's Hosp.; Oct. 16, 1975
(1) Anesthesia Case Conference; by **U. of Pa.**; intermittent during year (76-1-348)
(1) Learning Disabilities; by **U. of Pa.** (75-2-43)
Contact: William Schwartz, M.D., Chariman, Postgraduate Educ. Comm., Children's Hosp. of Phila., 34th & Civic Cntr. Blvd., Phila. 19104

Philadelphia: **Coll. Phys./Phila.**; '75-'76 Academic Year
(1) Second Career Training Program for Emergency Physicians; by **Hahnemann, Jefferson, MCP, Temple** and **U. of Pa.**; 15 days, Apr. 26-May 14 (76-1-113)
(1) Biology and Therapeutic Management of Human Cutaneous Malignan Melanomas; by **Temple**, Apr. 1-2 (76-1-191)
(1) Football Sports Medicine Weekend; by **Temple**, Oct. 10-12 (75-2-60)
(1) Endocrine Symposium: Medical and Surgical Aspects of Diseases of Thyroid Parathyroid and Adrenals; by **Temple**; Nov. 14-15 (75-2-64)
(1) 8th Annual Pediatric Ophthalmology Symposium; by **Temple**, St. Christopher's Hosp. and Wills Eye Hosp.; May 15-16 (76-1-167)
Contact: Albert J. Finestone, M.D., Assistant Dean, **Temple**

Philadelphia; **Colon and Rectal**; '75-'76 Academic Year
(1) Scientific Prgms.; at Union League; Sept. 19, Jan. 16, Mar. 12 and May 21 (76-1-3)
Contact: Indru T. Khubchandani, M.D., Secy., **Colon and Rectal**

Philadelphia; Episcopal Hosp.; '75-'76 Academic Year
(1) Metabolic/Endocrine Problems for Practicing Physician; by **Temple**; biweekly beginning July 11, 1975 (76-1-121)
(1) Phonocardiography/Vectorcardiography for the Practicing Physician; by **Tem-**

e. weekly Feb. 5-Mar. 11 (76-1-116)
(1) Electrocardiography for the Practicing Physician; by **Temple**, weekly, beginning ov. 13 (12 weeks) (76-1-117)
(1) Clinical Cardiology; by **Temple**; weekly, Sept. 10-June (76-1-287)
(1) Mortality Conference; by **Temple**; Monthly, July 17-June 18 (76-1-288)
(1) Gastroenterologic Problems for Practicing Physician; by **Temple**; biweekly ginning July 11, 1975 (76-1-118)
(1) General Medicine; by **Temple**, weekly beginning Oct. 11 (76-1-119)
(1) Hematology for Practicing Physician; by **Temple**; weekly Sept. 30-June 30 (76-1-0)
(1) Neurology Grand Rounds; by **Temple**; fourth Tues., Jan.-Dec. (76-2-8)
(1) Neurosurgical Seminar; by **Temple**; every Tues., Jan.6-Dec. 28 (76-2-9)
(1) General Histopathology; by **Temple**; daily Mon.-Fri., Jan 2-Dec. 31 (76-2-4)
(1) Combined Surgery, Radiology, Pathology Conference; by **Temple**; Thurs., n.6-Dec. 28 (76-2-5)
(1) Ob-Gyn Pathology; by **Temple**; Tuesdays, Jan. 6-Dec. 28 (76-2-11)
(1) Genito-urinary Pathology; by **Temple**; Wednesdays, Nov. 3-Dec. 29 (76-2-12)
ontact: Jacob Zatuchni, M.D., Dept. of Med., Episcopal Hosp., Front St. and Lehigh ve., Philadelphia 19125
(1) Introductory Diagnostic Ultrasound, by **Temple**; Sept. 22-26 (repeat Dec. 15-19, ar. 8-12, and June 14-18) (76-1-122)
(1) Diagnostic Ultrasound—Abdominal Scanning; by **Temple**; Oct. 20-24 (repeat Jan. 2-16 and Apr. 5-9) (76-1-123)
(1) Diagnostic Ultrasound—Echocardiography; by **Temple**; Nov. 17-21 (repeat Feb. 13 and May 10-14) (76-1-124)
(1) Neuroradiology-Pathology; by **Temple**; Tuesdays, Jan. 27-Dec. 28 (76-2-10)
(1) Radiology Conference; by **Temple**, weekly (76-2-13)
(1) Surgery Rounds; by **Temple**; Tuesdays, Jan. 6-Dec. 28 (76-2-6)
(1) Uroradiology Conference; by **Temple**; weekly (76-2-30)
ontact: LeRoy H. Stahlgren, M.D., Episcopal Hosp., Front St. and Lehigh Ave., hiladelphia 19125

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hiladelphia; **EPPI**; '75-'76 Academic Year
(1) Cultural Anthropology for Psychiatrists; Sept. 25-Oct. 2 (75-2-44)
(1) Biological Basis of Behavior; Thurs. in Nov. (75-2-45)
(1) Sleep; Thurs. in Nov. (75-2-46)
(1) Biofeedback—What is It? What is It For? How is It Done?; Thurs. in Apr. (76-1-114)
(1) Legal & Political Issues Relevant to the Practice of Psychiatry; date to be deter-ined (76-1-115)
(1) Psychiatric Manifestations Due to Medical Problems; Thurs. in Dec. (75-2-47)
ontact: Geraldine DePaula, M.D., Acting Dir. of CME, **EPPI.**
(1) Behavioral Techniques for the General Practitioner; by **Temple**; weekly, Sept. 7-Nov. 19 (75-2-61)
(1) Seminar in Clinical Behavior Therapy; by **Temple**; weekly, Sept. 10-Dec. 3, 1975 epeat Jan. 7-Mar. 31, 1976) (76-1-205)
(1) Training Program in Behavior Therapy; by **Temple**; 20 days, June 7-July 2, 1976 6-1-206)
ontact: Albert J. Finestone, M.D., Assistant Dean, **Temple**

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hiladelphia; **Frankford**; '75-'76 Academic Year
(1) Continuing Education for Physicians; weeky, Sept. 5-June 25 (76-1-299)
ontact: Ronald E. Cohn, M.D., Med. Dir., **Frankford**

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hiladelphia; Fels Research Institute; '75-'76 Academic Year
(1) Basic Science Seminar; by **Temple**; one day per week, Sept.-June (76-1-125)
ontact. Albert J. Finestone, M.D., Assistant Dean for Cont. Med. Educ., **Temple.**

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hiladelphia; Germantown Dispensary & Hosp.; '75-'76 Academic Year
(1) Continuing Education in Diagnostic Radiology; by **Temple**; Mondays, Sept.-June 76-1-126)
(1) Continuing Medical Education Conference; by **Temple**, Fridays, Sept. 12-June 4 76-1-127)
ontact: William H. Strimel, M.D., Chrm., Med. Educ. Comm., Germantown Dispensary Hosp., Penn and Wister Sts., Philadelphia 19144

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hiladelphia; **Hahnemann**, '75-'76 Academic Year
(1) Clinical Immunology Tutorial Course; 40 days/repeated Sept. 1-June 25 (76-1-32)
(1) Rheumatology Tutorial Course; two days per week, four weeks/repeated Sept. -July 1 (76-1-131)
(1) Noninvasive Cardiac Techniques Tutorial; 15 days/repeated Oct. 6-June 4 (76-1-34)
(1) Vector-Electrocardiography and Cardiovascular Pharmacology Tutorial; 15 ays/repeated Oct. 6-June 4 (76-1-135)
(1) Bedside Diagnosis of Heart Disease; at Marriott Motor Hotel; July 12-24 (76-1-136)
(1) Electrocardiography for the Practitioner; at Valley Forge Sheraton Hotel; Nov. 3-25 (75-2-49)
(1) Electrocardiology for the Internist, at Valley Forge Sheraton Hotel; Apr. 7-9 76-1-137)
(1) Cardiology; at Marriott Motor Hotel; May 24-28 (76-1-138)
(1) Clinical Cardiology and Cardiovascular Surgery Tutorial; 15 days/repeated Oct. -June 4 (76-1-139)
(1) Cardiac Radiology and Angiography Tutorial; 15 days/repeated Oct. 6 -June 4 76-1-140)
(1) Cardiac Care Unit Tutorial; 15 days/repeated Oct. 6-June 4 (76-1-141)
(1) Hypertension, Clinical and Laboratory Tutorial; 10 days/repeated Sept. 1-June 18 (76-1-142)
(1) Fluid and Electrolyte Metabolism Tutorial; 10 days/repeated Sept. 1-June 18 (76-1-143)
(1) Dialysis Tutorial Course; 10 days/repeated Sept. 1-June 18 (76-1-144)
(1) Respiratory Intensive Care Tutorial; 20 days/repeated Sept. 1-July 2 (76-1-133)
(1) Workshops in Respiratory Intensive Care; Oct. 20-31 (repeated Apr. 12-23) (76-1-145)
(1) Respiratory (inhalation) Therapy Tutorial; 20 days/repeated Sept. 1-July 2 (76-1-146)
(1) Clinical Pulmonary Disease Tutorial; 20 days/repeated Sept. 1-July 2 (76-1-148)
(1) Critical Care Tutorial Course; 40 days/repeated Nov. 3-June 25 (76-1-149)
(1) Infectious Diseases/Hospital Infections; at Bellevue Stratford; Apr. 21-23 (76-1-27)
(1) Endocrinology and Diabetes; at Bellevue Stratford Hotel; Feb. 2-4 (76-1-150)
(1) Controversies in Family Medicine; at Bellevue Stratford Hotel; June 7-9 (76-1-151)
(1) Current Concepts in Medicine; Wednesdays, Oct. 1-May 26 (76-1-296)
(1) Review Seminar for Foreign Medical Graduates; Nov. 10-Dec. 19; (repeated May 10-June 25, 1976; Nov. 8-Dec. 17, 1976) (76-2-1)
(1) Clinical Gastroenterology Tutorial; weekly, Sept. 18-Oct. 23 (repeated Mar. 18-Apr. 22) (76-1-152)
(1) Gastrointestinal Endoscopy Tutorial; 5 days/repeated monthly Sept.-June (76-1-153)
(1) Basic Medicine Tutorial Course; 60 days/repeated Sept. 8-June 26 (76-1-154)
(1) Chairman's Medical Grand Rounds; every Thurs., Oct. 9-May 27 (76-1-155)
(1) Clinical Skills for Physician Assistants III; at Sheraton Hotel; Oct. 19-22 (75-2-50)
(1) Role of Computerized Transaxial Tomography on Diagnosis on Organic Brain Disease; four times yearly, Sept.-May (76-1-28)
(1) Sports Medicine; by McGraw-Hill Publications; at Valley Forge Sheraton Hotel; Sept. 22-24 (75-2-51)
(1) Acid-Base and Electrolyte Balance; at Sheraton Hotel; Oct. 13-15 (75-2-53)
(1) Internal Medicine Reviews; every Wed., Oct. 1-May 26 (76-1-156)
(1) Adult Neurology Tutorial; 60 days/repeated Oct. 6-June 25 (76-1-157)
(1) Pediatric Neurology Tutorial; 60 days/repeated Oct. 6-June 25 (76-1-158)
(1) Neuropathology Tutorial; 60 days/repeated Oct. 6-June 25 (76-1-159)
(1) Pulmonary Physiology Tutorial; 20 days/repeated Sept. 1-July 2 (76-1-147)
(1) Gastrointestional Radiology Conference; first and third Fridays, Sept.-June (76-1-128)
(1) Radiology-Renal Conference; second and fourth Wednesdays, Sept.-June (76-1-129)
(1) Radiology-Pulmonary Conference; first and third Wednesdays, Sept.-June (76-1-130)
Contact: Robert J. Schaefer, Exec. Dir., Cont. Educ. Prgm. Coordinator, **Hahnemann**

Philadelphia; Institute for Cancer Research; Mar. 31, 1976
(1) Cancer Medicine for the Practicing Physician; by **Jeanes** and Fox Chase Cancer Cntr.; (76-1-405)
Contact: Paul F. Engstrom, M.D., Chief, Dept. of Med., Amer. Oncologic Hosp., Central and Shelmire Ave., Philadelphia 19111

Philadelphia; **Jeanes**; '75-'76 Academic Year
(1) Diagnosis and Treatment of Cardiac Arrhythmia; weekly, Feb. 25-Mar. 31 (76-1-385)
(1) Pulmonary Diseases for Practicing Physicians; weekly, Apr. 7-May 12 (76-1-386)
(1) Dermatology for Family Physicians; weekly, Jan. 14-Feb. 18 (76-1-387)
(1) Management of Trauma in Office Practice; weekly, Sept. 1-Oct. 15 (75-2-117)
(1) Clinical Rounds (Medical Dept.); weekly, Sept. 10-June 2 (76-1-401)
(1) Weekly Scientific Conference; 1 day every other week; Sept. 17-June 30 (76-1-402)
(1) Hematology for Practicing Physicians; weekly, Oct. 22-Dec. 10 (75-2-121)
(1) Recent Aspects of Neurologic Therapies—1975 Annual Symposium; Nov. 19 (75-2-122)
(1) Medical Dept. Meeting—Scientific; monthly, Sept. 24-June 23 (76-1-403)
(1) Pathology Slide Conference; weekly, Sept. 2-Aug. 29 (76-1-408)
(1) Radiology Conference; Tuesdays and Fridays, Sept. 2-August 29 (76-1-409)
(1) Surgical Department Meeting—Scientific; monthly, Oct. 1-Aug. 4 (76-1-410)
Contact: Joseph M. Winston, M.D., Dir., Dept. of Med Educ., **Jeanes**

Philadelphia; **Jefferson**; '75-'76 Academic Year
(1) Endocrine Therapeutics in Practice; Nov. 12-14 (75-2-114)
(1) New Concepts in Basic and Applied Hematology; by **ACP**, Oct. 8-10 (75-2-116)
(1) Review Course in Family Medicine; Oct. 1-3 (75-2-100)
(1) Modern Therapeutics II; Feb. 25-27 (76-1-293)
Contact: John H. Killough, M.D., Associate Dean, **Jefferson**

Philadelphia; Lankenau Hosp.; Sept. 22-26, 1975
(1) Core Curriculum: Mechanisms and Therapy of Cardiac Arrhythmias; by **Amer. Coll. of Cardiology** and **Jefferson** (75-2-89)
Contact. Mary Anne McInerny, Dir., Dept. of Cont. Educ., **Amer. Coll. of Cardiology**, 9650 Rockville Pike, Bethesda, Md. 20014

Philadelphia, **MCP**; '75-'76 Academic Year
(1) Preceptorships for Practicing Physicians (in all sub specialties); scheduled as

convenient (76-2-31)
Contact Gerald H. Escovitz, M.D., Assoc. Dean, **MCP**

(1) Retraining Program; six week review of physical diagnosis skills. (76-2-32)
Contact. Ethel Weinberg, M.D., Assoc. Dean, **MCP**

Philadelphia; Memorial Hosp. of Roxborough; Sept. 16-Oct. 28, 1975
(1) Nephrology; by **PAFP**, one day ea. week (75-2-91)
Contact. Herbert M. Schiller, M.D., Dir., 479 Lyceum Ave., Philadelphia 19128

Philadelphia; Moss Rehab. Hosp., Albert Einstein Med. Cntr.; '75-'76 Academic year
(1) Rheumatology Teaching Conference; by **Temple**; weekly, Sept.-May (76-1-85)
Contact Morton S. Mandell, M.D., Ch. Cont. Educ. SubComm., Albert Einstein Med. Cntr., York & Tabor Road, Philadelphia 19141

Philadelphia; Nazareth Hosp.; Nov. 5, 1975
(1) Diabetes; by **Temple**, four hours (75-2-54)
Contact Albert J. Finestone, M.D., Assistant Dean, Cont. Med. Educ., **Temple**

Philadelphia; **PMS**, 1976
(1) Establishing Yourself in Medical Practice; Jan. 6-7; at Philadelphia Co. Med. Soc. Headquarters (76-1-294)
Contact: LeRoy C. Erickson, Dir. of Educ. Activities, Cncl. on Educ. & Science, **PMS**

Philadelphia, Pennsylvania Hosp.; Mar. 1-5, 1976
(1) Specifically Treatable Diseases; by **ACP** (76-1-338)
Contact M.H. Jackson, Registrar, **ACP**

Philadelphia; Philadelphia State Hosp.; '75-'76 Academic Year
(1) Continuing Medical Education for Physicians; by **Temple**, weekly, Sept. 5-Jan. 23 (76-1-160)
(1) Seminars for Psychiatrists; by **Institute**; every other week. Apr. 9-May 28 (76-1-285)
(1) Seminars for Psychiatrists; by **Jefferson**; every other week, Jan. 30-Mar. 26 (76-1-161)
Contact Donald Daiter, M.D., Prgm. Dir., Philadelphia State Hosp. 14000 Roosevelt Blvd., Philadelphia 19131.

Philadelphia; Skin and Cancer Hosp.; '75-'76 Academic Year
(1) Clinical Dermatology Conference; by **Temple**; weekly, Sept. -June (76-1-162)
(1) 18th Annual Postgraduate Course in Dermal Pathology; by **Temple**; Aug. 22-27, 1976 (76-1-163)
(1) Third Postgraduate Course in Medical Mycology; by **Temple**, June 21-25 (76-1-194)
Contact Albert J. Finestone, M.D., Assistant Dean, **Temple**

Philadelphia; St. Christopher's Hosp. for Children; '75-'76 Academic Year
(1) Pediatric Grand Rounds; by **Temple**; Tuesdays and Fridays, Sept.-June (76-1-164)
(1) Pediatric Conference; by **Temple**; weekly, Sept.-June (76-1-165)
(1) Pediatric Cardiology Conference; by **Temple**; weekly, Sept.-June (76-1-166)
Contact Alan Gruskin, M.D., Associate Professor in Pediatrics, **Temple**
(1) 25th Annual Pediatric Seminar; by **Temple**, at Benjamin Franklin Hotel; June 1-4, 1976 (76-1-168)
Contact Albert J. Finestone, M.D., Assistant Dean, **Temple**

Philadelphia; **Temple**, '75-'76 Academic Year
(1) Anesthesiology Basic Science Lecture; weekly, Sept.-June (76-1-171)
(1) Anesthesiology Case Conference; weekly, Sept.-June (76-1-172)
(1) Anesthesiology Seminar, weekly, Sept.-June (76-1-173)
(1) Anatomy Conference and Class; weekly, Sept.-June (76-1-170)
(1) Basic Science (Surgery) Review; weekly, Sept.-June (76-1-174)
(1) Angiography; weekly, Sept.-June (76-1-175)
(1) Cardiac Arrhythmia Conference; weekly, Sept.-June (76-1-176)
(1) Cardiac Catheterization Conference; weekly, Sept.-June (76-1-177)
(1) Thrombohemorrhagic Conference; weekly, Sept.-June (76-1-178)
(1) Chest Conference; weekly, Sept.-June (76-1-179)
(1) Pulmonary Grand Rounds; weekly, Sept.-June (76-1-180)
(1) Electrodiagnostic Rounds; weekly, Sept.-June (76-1-181)
(1) Endocrine-Metabolic Conference; weekly, Sept.-June (76-1-182)
(1) G.I. Conference; weekly, Sept.-June (76-1-183)
(1) Cardiology in Office Practice; Apr. 28, 1976 (76-1-184)
(1) Chamberlain Lecture; Oct. 21, 1975 (75-2-55)
(1) Stauffer Memorial Lecture; Apr. 28, 1976 (76-1-217)
(1) First Annual Weiss-English Psychosomatic Program; Oct. 11, 1975 (75-2-56)
(1) Socratic Seminars; arranged on request of applicant (76-2-14)
(1) Recent Advances in Medicine; one day per week, Oct. 15-Dec. 3 (75-2-57)
(1) Infectious Disease in Office Practice; May 5, 1976 (76-1-185)
(1) Diabetes Mellitus in Office Practice; Apr. 14, 1976 (76-1-186)
(1) Medical Grand Rounds; weekly, Sept.-June (76-1-192)
(1) CPC/Medicine; weekly, Sept.-June (76-1-193)
(1) Fracture Conference; weekly, Sept.-June (76-1-187)
(1) Rheumatology Conference; weekly, Sept.-June (76-1-216)
(1) Hepatology Conference; weekly, Sept.-June (76-1-188)
(1) A Day in Hematology; Mar. 24, 1976 (76-1-190)
(1) Infectious Disease Clinical Microbiology Conference; weekly, Sept.-June (76-1-189)
(1) International Conference on Neural Control of Locomotion; at Sheraton Valley Forge Hotel; Sept. 29-Oct. 2 (75-2-58)
(1) Neurology Conference; weekly, Sept.-June (76-1-195)
(1) Grand Rounds in Neurosurgery; weekly, Sept.-June (76-1-196)
(1) Ob/Gyn Grand Rounds; weekly, Sept.-June (76-1-197)
(1) Modern Concepts in Evaluation and Management of Pelvic Malignancy (Forman); Nov. 17 (75-2-59)
(1) Ob/Gyn Postgraduate Program; Wednesdays, Sept.-June (76-1-198)
(1) Hematology-Oncology Conference; weekly, Sept.-June (76-1-199)
(1) Tumor Conference; weekly, Sept.-June (76-1-219)
(1) Orthopedic Surgery Basic Science Conference; weekly, Sept.-June (76-1-169)
(1) Orthopedic Surgery Grand Rounds; weekly, Sept.-June (76-1-200)
(1) Mini Fellowships in Sports Medicine; by arrangement (76-2-15)
(1) Patient Care Mortality & Morbidity Conference (ORS); weekly, Sept.-June (76-1-201)
(1) Orthotic Rounds; weekly, Sept.-June (76-1-202)
(1) Chevalier Jackson Basic Course in Bronchoesophagology; Nov. 10-21 (repeated Feb. 2-13) (76-1-203)
(1) ENT Workshop; in varying locations; varying days; 2 hours (76-2-16)
(1) Grand Rounds in Psychiatry; weekly, Sept.-June (76-1-204)
(1) Frontiers of Psychotherapy; by Albert Einstein Med. Center, Northern Div., at Holiday Inn; Mar. 18-19, 1976 (76-1-207)
(1) Second Annual Temple Conference on Behavior Therapy and Behavior Modification; at Hilton Hotel; Oct. 9-12, 1975 (75-2-62)
(1) Rehabilitation Chairman's Rounds; weekly, Sept.-June (76-1-215)
(1) Radiology in the Emergency Department; Nov. 12, 1975 (75-2-63)
(1) Clinical Pathology Radiology Conference; weekly, Sept.-June (76-1-208)
(1) Neuroradiology; weekly, Sept.-June (76-1-209)
(1) Neuroradiology Conference; weekly, Sept.-June (76-1-210)
(1) Orthopedic Radiology; weekly, Sept.-June (76-1-211)
(1) Pediatric Radiology; weekly, Sept.-June (76-1-212)
(1) Urologic Radiology; alternate Thursdays, Sept.-June (76-1-213)
(1) Urologic Radiology Conference; weekly, Sept.-June (76-1-214)
(1) Surgical Morbidity Conference, weekly, Sept.-June (76-1-218)
Contact: Albert J. Finestone, M.D., Assistant Dean, Cont. Med. Educ., **Temple**

Philadelphia; **U. of Pa.**; '75-'76 Academic Year
(1) Allergy-Immunology Clinical Conference; weekly (76-1-380)
(1) Allergy-Immunology Journal Club/Research Conference; weekly (76-1-381)
(1) Anesthesia Case Conference; intermittent during year (76-1-341)
(1) Clinical Cardiovascular Conference; intermittent during year (76-1-342)
(1) Cardiovascular Hypertension Clinical and Research Rounds; weekly (76-1-369)
(1) Cardiovascular Hypertension Conference; weekly (76-1-370)
(1) Cardiology Clinical Conference; weekly (76-1-382)
(1) Congenital Heart Disease Conference; weekly (76-1-384)
(1) Dermatology Conference and Rounds; intermittent during year (76-1-343)
(1) Infectious Disease Conference; weekly (76-1-363)
(1) Renal-Electrolyte Section Conference; weekly (76-1-364)
(1) Diabetes and Endocrine Conference; weekly (76-1-365)
(1) Workshops in Physiology, Diagnosis and Treatment of Electrolyte and Acid-Base Disorders; by **ACP**; Jan. 5-9 (76-1-336)
(1) Gastroenterology Interdisciplinary Conference; weekly (76-1-366)
(1) Gastroenterology Research Seminar; weekly (76-1-367)
(1) Gastroenterology Clinical Conference; weekly (76-1-368)
(1) Hematology-Oncology Conference; weekly (76-1-371)
(1) Hematology Clinical Conference; weekly (76-1-373)
(1) Pathology Soc. of Philadelphia; intermittent during year (76-1-345)
(1) Suburban Pathology Conference; intermittent during year (76-1-361)
(1) Clinical Pathology Conference; intermittent during year (76-1-350)
(1) Dermato-Pathology Conference; intermittent during year (76-1-351)
(1) Neuropathology Brain-Cutting Conference; intermittent during year (76-1-352)
(1) Oncology Clinical Conference; weekly (76-1-372)
(1) Pediatric Surgical Grand Rounds; intermittent during year (76-1-349)
(1) PM and R Teaching Conference; intermittent during year (76-1-354)
(1) PM and R Psychiatric Conference; intermittent during year (76-1-355)
(1) PM and R Prosthetic-Orthotic Conference; intermittent during year (76-1-356)
(1) Electrophysiology Conference; weekly (76-1-383)
(1) Psychiatry Academic Seminar; intermittent during year (76-1-346)
(1) Medical-Surgical Chest Conference; weekly (76-1-375)
(1) Clinical Pulmonary Management Conference; weekly (76-1-376)
(1) Pulmonary Research Conference; weekly (76-1-377)
(1) Pulmonary Function Conference; weekly (76-1-378)
(1) Chest X-Ray Conference; weekly (76-1-379)
(1) Pulmonary Grand Rounds; weekly (76-1-374)
(1) Pulmonary/Medical/Surgical Conference; intermittent during year (76-1-359)
(1) Philadelphia Angiography Club; intermittent during year (76-1-340)
(1) Neuroradiology Clinical Correlation Conference; intermittent during year (76-1-353)
(1) Neuroradiology Conference; intermittent during year (76-1-344)
(1) Tumor Conference; intermittent during year (76-1-357)
(1) Rheumatology Conference; weekly (76-1-362)

(t) Surgical Conference; intermittent during year (76-1-360)
(1) Surgical Grand Rounds; intermittent during year (76-1-347)
(1) Mortality/Morbidity Conference; intermittent during year (76-1-358)
Contact: Henry G. Sparks, Coordinator, Cont. Educ. Program, **U. of Pa.**

Philadelphia; Wills Eye Hosp.; '75-'76 Academic Year
(1) Vascular Diseases of the Ocular Fundus; by **Jefferson**, Mar. 6-7, 1976 (76-1-289)
Contact: Richard E. Goldberg, M.D., Retina Service, Wills Eye Hosp., 1601 Spring Garden St., Philadelphia 19130.

Pittsburgh; Children's Hosp.; '75-'76 Academic Year
(1) Emergencies in the Home; by **Pitt.**; Oct. 3-4 (75-2-69)
Contact: Donald H. Reigel, M.D., Dir., Children's Hosp., 125 Desoto St., Pittsburgh 15213

Pittsburgh; Eye and Ear Hosp.; '75-'76 Academic Year
(1) Anatomy and Surgery of the Nose; by **Pitt.**; Feb. 8-14 (76-1-239)
Contact: Kenneth H. Hinderer, M.D., Course Dir., Eye and Ear Hosp., 230 Lothrop St., Pittsburgh 15213
(1) Phaco-Emulsification: Surgical Techniques; by **Pitt.**; Oct. 23-25 (75-2-72)
(1) Phaco-Emulsification: Surgical Techniques; by **Pitt.**; Jan. 22-24 (76-1-238)
(1) Phaco-Emulsification: Surgical Techniques; by **Pitt.**; Mar. 11-13 (76-1-240)
(1) Phaco-Emulsification: Surgical Techniques; by **Pitt.**; May 13-15 (76-1-246)
Contact: Francis Hurite, M.D., Course Dir., Eye and Ear Hosp., 230 Lothrop St., Pittsburgh 15213
(1) Surgical Anatomy and Techniques of the Temporal Bone; by **Pitt.**, Nov. 2-8 (75-2-77)
Contact: Ralph J. Caparosa, M.D., Course Dir., Eye and Ear Hosp., 230 Lothrop St., Pittsburgh 15213

Pittsburgh; Magee Womens Hosp.; '75-'76 Academic Year
(1) Mortality and Morbidity Study and Guest Lecturer; by **Anesthesiologists** and Western Pa. Soc. of Anesthesiologists; third Thurs., Sept. 18-May 20 (76-1-23)
Contact: R. Brian Smith, M.D., Dept. of Anesthesiology, Eye & Ear Hosp., Pittsburgh 15213
(1) Seminar and Workshop in Diagnostic and Operative Laparoscopy; by **Pitt.**; Nov. 13-14 (75-2-80)
Contact: David L. Katz, M.D., Course Dir., Magee-Womens Hosp., Forbes Ave. and Halket St., Pittsburgh 15213

Pittsburgh; **Mercy**; '75-'76 Academic Year
(1) Anesthesiology Basic Science Lectures; weekly, Aug. 20-June 23 (76-1-220)
(1) Anesthesiology Resident Seminar; weekly, Sept. 4-June 24 (76-1-221)
(1) Cardiology Conferences; weekly, Sept. 3-June 23 (76-1-222)
(1) Medical Quarterly Conference; Sept. 10, Dec. 10, March 10, June 9 (76-1-223)
(1) Mercy Day Scientific Conference; Sept. 19 (75-2-4)
(1) Medical Resident Seminars; weekly, Sept. 6-June 26 (76-1-229)
(1) Medical Grand Rounds; weekly, continual (76-2-17)
(1) Medical Mortality Session; weekly, continual (76-2-18)
(1) Neurology and Neurosurgery Conference; weekly, continual (76-2-19)
(1) Otolaryngology Clinical Pathology Conference; monthly, continual (76-2-20)
(1) Plastic Reconstructive Surgery Conference; 30 times between Sept. 4-June 17 (76-1-224)
(1) Otolaryngology and Maxillofacial Conference; weekly, Sept. 6-June 26 (76-1-226)
(1) Concepts in Soft Tissue Surgery; Jan. 26-30 (76-1-227)
(1) Otology Conference; weekly, Sept. 25-June 24 (76-1-228)
(1) Joint Orthopedic Conference; every other week, Sept. 9-May 25 (76-1-225)
(1) Tumor Board; weekly, continual (76-2-21)
(1) Pediatric Grand Rounds; weekly, continual (76-2-22)
(1) Pediatric Conference; weekly, continual (76-2-23)
(1) Radiology-ENT Conference; monthly, Sept. 5-May 7 (76-1-230)
(1) Radiology-Gastroenterology Correlative Conference; monthly, Sept. 19-May 21 (76-1-231)
(1) Radiobiology Conference; monthly, Sept. 26-May 28 (76-1-232)
(1) Surgical Mortality Session; weekly, continual (76-2-24)
(1) General Surgical Conference; weekly, continual (76-2-25)
Contact: John J. Kenny, M.D., Chrm., Cont. Med. Educ., **Mercy/Pgh.**

Pittsburgh; Montefiore Hosp.; '75-'76 Academic Year
(1) Contemporary Problems in Surgery; by **Pitt.**; June, 1976 (76-1-249)
Contact: Felicien M. Steichen, M.D., Dir., Montefiore Hosp., 3459 Fifth Ave., Pittsburgh 15213

Pittsburgh; North Hills Passavant Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**; monthly, Sept. 24, 1975-May 27, 1976 (76-1-233)
Contact: Herbert Anderson, M.D., North Hills Passavant Hosp., Pittsburgh 15237

Pittsburgh; **PMS**; 1976
(1) Establishing Yourself in Medical Practice; Jan. 13-14; at Allegheny Co. Med. Soc., Headquarters (76-1-295)
Contact: LeRoy C. Erickson, Dir. of Educ. Activities, Cncl. on Educ. & Science, **PMS**

Pittsburgh; **Pitt**, '75-'76 Academic Year
(1) The Many Faces of Alcoholism, Oct. 24-26 (75-2-71)
(1) Practical Clinical Dermatology; Oct. 23-25; at Marriott Inn (75-2-74)
(1) Diabetes Symposium; Nov. 20; at Holiday Inn, Greentree (75-2-81)
(1) Biochemical Mechanisms of Disease; monthly, Jan. 13-April 6 (76-1-237)
(1) Seminars in Clinical Cardiology; 2nd Wednesday ea. month, Sept.-May (except December) (76-1-284)
(1) Diseases Due to Immune Mechanisms; at Wm. Penn Hotel; Sept. 25-28 (75-2-22)
(1) 1976 International Congress on Emergency and Critical Care Medicine; May 4-8 at William Penn Hotel (76-1-245)
(1) Hematology Review; Sept. 13-17, 1976 (76-2-26)
(1) Infection and Infection Controls in the Hospital and Health Care Facilities; Oct. 8-10, at Webster Hall Hotel (75-2-70)
(1) Internal Medicine Board Review Course; April-May (76-1-244)
(1) Family Medicine, A Refresher Course and Practice Examination for Family Physicians; Sept. 18-21; at Hilton Hotel (75-2-66)
(1) Seminars for the Practicing Physician; Wednesdays or Thursdays, Sept. 24-Dec. 4 (75-2-68)
(1) Lunch Box Theater; Wednesdays, Sept. 10-Dec. 3 (75-2-67)
(1) Microneurosurgery of the Cranial Nerves; Sept. 17-20 (75-2-65)
(1) Multiple Sclerosis Symposium; May 26 (76-1-248)
(1) Office Problems and How to Solve Them; Oct. 17-18 (75-2-73)
(1) Moving Points in Rheumatology and Clinical Immunology; by **ACP**, May 12-15 (76-1-247)
(1) Clinical Neuro-Otolaryngology; Mar. 25-27 (76-1-241)
(1) Third OB-GYN Anesthesia Symposium; Nov. 1 (75-2-83)
(1) Bone Marrow Biopsy for Pathologists; Nov. 7-8 (75-2-79)
(1) American Psychosomatic Society; Mar. 26-28 (76-1-242)
(1) Electronic Imaging Techniques in Diagnostic Radiology; Apr. 8-10; at Seven Springs Mtn. Resort (75-2-23)
(1) Sexual Dysfunction: When to Counsel, When to Refer, Sept. 19-20; at Western Psychiatric Institute & Clinic (75-2-90)
(1) Fifth Workshop in the Use of Staplers in Surgery; Nov. 3-4 (75-2-76)
(1) Trauma; Nov. 14 (75-2-82)
Contact: William M. Cooper, M.D., Dir., Div. of Cont. Educ., **Pitt**

Pittsburgh; **St. Francis**, '75-'76 Academic Year
(1) Seminar in Pulmonary Physiology and Medicine; Sept. 4-6 (75-2-31)
Contact: S. Grover, M.D., Dir., Pulmonary Med. Div., **St. Francis**

Pittsburgh; St. Johns Gen. Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**, monthly, Sept. 17-June 16 (Feb.-June sessions at Suburban Gen. Hosp.) (76-1-251)
Contact: R.J. Wojciak, D.O., St. Johns Gen. Hosp. 3339 McClure Ave., Pittsburgh 15212

Pittsburgh; **St. Margaret**, '75-'76 Academic Year
(1) Cardiology Conferences, Every other Friday, Sept. 1-Aug. 31 (76-1-252)
(1) Community and Family Practice Seminars: Every other Monday, Sept. 1-Aug. 31 (76-1-253)
(1) Continuing Medical Education Postgraduate Lectures; Thursdays, Sept. 1-Aug 31 (76-1-254)
(1) Family Practice Medical Conferences; Saturdays except last Saturday of month (76-1-255)
(1) Seminars for the Family Physician; Oct. 2, Jan. 15, and Apr. 7 (76-1-256)
(1) Rehabilitation Team in Action; weekly, Sept. 1-Aug. 31 (76-1-257)
(1) Grand Medical Rounds; weekly, Sept. 1-Aug. 31 (76-1-258)
(1) Selected Topics in Rheumatology; weekly, Sept. 1-Aug. 31 (76-1-259)
(1) Rheumatology-Radiology Review; weekly, Sept. 1-Aug. 31 (76-1-260)
(1) Rheumatology-Pathology Review; weekly, Sept. 1-Aug. 31 (76-1-261)
(1) Rheumatology Grand Rounds; monthly, Sept. 1-Aug. 31 (76-1-262)
(1) Arthritis and the Rehabilitation Team; weekly, Sept. 1-Aug. 31 (76-1-263)
(1) Neurology Conferences; second and fourth Fridays of each month, Sept. 1-Aug. 31 (76-1-264)
(1) OB-GYN Conferences; every other Tuesday, Sept. 1-Aug. 31 (76-1-265)
(1) Workshop in Rheumatology and Orthopedics; 6 days a month for 12 months, Sept. 1-Aug. 31 (76-1-266)
(1) Rheumatology for the Orthopedic Surgeon; weekly, Sept. 1-Aug. 31 (76-1-267)
(1) Pediatric Conference; every other Tuesday, Sept. 1-Aug. 31 (76-1-268)
(1) Psychiatry Seminars in Family Practice; every Thursday, Sept. 1-Aug. 31 (76-1-269)
(1) Radiology Conferences; every other Friday, Sept. 1-Aug. 31 (76-1-270)
Contact: Paul W. Dishart, M.D., D.M.E., **St. Margaret**

Pittsburgh; Staunton Clinic; '75-'76 Academic Year
(1) 19th Annual Series of Seminars in Patient Care; by **Pitt.**; Wednesdays, Sept. 17-Jan. 7 (76-1-234)
(1) Case Centered Seminars in Psychotherapy; 10 sessions; to be arranged; by **Pitt** (76-1-235)
(1) Seminar for Leaders in Group Process of Consultation; by **Pitt.**; Thursdays by arrangement (76-1-236)
Contact: Rex A. Pittenger, M.D., Dir., Staunton Clinic, 3601 Fifth Ave., Pittsburgh 15213.

Pittsburgh; Suburban Gen. Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**, monthly, Sept. 17-June 16; (Sept.-Jan. sessions at St. John's Gen. Hosp.) (76-1-251)

Contact Donald D. Davis, M.D., Suburban Gen. Hosp., S. Jackson Ave., Pittsburgh 15202

Pittsburgh; **West Penn** '75-'76 Academic Year
(1) Dermatology Conference; Second and Fourth Tuesdays (75-2-17)
(1) Gastroenterology Conference; First Mondays (75-2-5)
(1) Hematology Conference, Second and Fourth Wednesdays (75-2-16)
(1) Medical Grand Rounds; First, Second, Third and Fifth Thursdays (75-2-15)
(1) Medical Mortality Conference; Fourth Thursdays (75-2-14)
(1) Metabolic/Endocrine/Renal Conference; Second and Fourth Mondays (75-2-6)
(1) Psychiatry Symposium; Second and Fourth Fridays (75-2-13)
(1) Pulmonary Conference; First, Third and Fifth Tuesdays (75-2-18)
(1) Rheumatology Conference, Third Monday (75-2-19)
(1) OB/GYN Grand Rounds, every Friday (75-2-7)
(1) Pediatric Visiting Professor Rounds, every Tuesday (75-2-8)
(1) Surgical Mortality Conference; Fourth Fridays (75-2-9)
(1) Surgical Grand Rounds; Second, Third and Fifth Fridays (75-2-10)
(1) Chest and Vascular Conference; Second and Fourth Thursdays (75-2-11)
(1) Surgery/Radiology/Pathology Conference; Second and Fourth Tuesdays (75-2-12)
Contact: James B. Hanrahan, M.D., Vice Chrm., Postgraduate Educ. Comm., **West Penn**

Pottsville; Good Samaritan Hosp.; '75-'76 Academic Year
(1) Cont. Educ. for Physicians; by **U. of Pa.**; monthly, Sept. 25-May 27 (76-1-5)
Contact: Norman W. Wall, M.D., DME, Good Samaritan Hosp., Norwegian & Tremont Sts., Pottsville 17901

Pottsville; Pottsville Hosp., '75-'76 Academic Year
(1) Postgraduate Seminars for Physicians, by **Jefferson**, monthly, Sept. 4-June 3 (76-1-6)
Contact: Edward Cubler, M.D., DME, Pottsville Hosp. and Warne Clinic, 420 S. Jackson St., Pottsville 17901

Reading; Family Guidance Center; 1975
(1) Introduction to Transactional Analysis; by **Reading**; Oct. 4 (75-2-39)
Contact: G. Carl Pettinato, Ph.D., Dir. of Psychological Services, Family Guidance Center, 844 Centre Ave., Reading 19601

Reading; St. Josephs Hosp.; '75-'76 Academic Year
(1) Medical Seminars, by **M.S. Hershey**, dates to be announced (76-1-302)
Contact: Ray Snyder, Dir. Cont. Med. Educ., **M.S. Hershey**

Roaring Spring, Nason Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**; monthly, Sept. 2, 1975-June 1, 1976 (76-1-271)
Contact: Marion A. Morelli, M.D., Nason Hosp., Roaring Spring 16673

Sayre; **Packer**, '75-'76 Academic Year
(1) The Pulmonary Patient: Anesthetic and Surgical Considerations; by **Anesthesiologists;** Jan. 24, 1976 (76-1-25)
Contact: E.A. Talmage, M.D., Dept. of Anesthesiology, **Packer**
(1) Anesthesia Conference; every Monday (76-1-272)
(1) Mammography, Angiography, Tomography for Radiologists (76-2-29)
(1) Endotracheal Intubation (76-2-28)
(1) Anesthesiology in Cardiac Patients (76-2-27)
(1) Clinical Pathological Conference; third Wednesday each month (76-1-273)
(1) Medical Grand Rounds; every Friday (76-1-274)
(1) Medicine Postgraduate Day; Nov. 15, 1975 (75-2-84)
(1) The Pulmonary Patient Undergoing Anesthesia and Surgery; Jan. 24, 1976 (76-1-25)
(1) Psychopharmacologic Agents in Primary Care Practice; Oct. 18, 1975 (75-2-85)
(1) Tumor Conference, second and fourth Thursdays each month (76-1-277)
(1) Surgical Grand Rounds, Saturdays (76-1-275)
(1) Surgical Postgraduate Day; March 13, 1976 (76-1-276)
Contact: Paul C. Royce, M.D., Ph.D., DME, **Packer**

Sharon; Sharon Gen. Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**; monthly, Sept.-Mar. (76-1-280)
Contact: Allen H. Holt, M.D., Sharon Gen. Hosp., Sharon 16147
(1) Continuing Education for Physicians; by **Pitt**; monthly, Oct.-June (76-1-279)
Contact: Thomas V. Murray, M.D., Sharon Gen. Hosp., Sharon 16147

St. Marys; Andrew Kaul Mem. Hosp.; 1975
(1) Continuing Education for Physicians, by **Pitt**, weekly beginning Sept. 1975 (75-2-93)
Contact: B.L. Coppolo, M.D., Andrew Kaul Mem. Hosp., St. Marys 15857

Sunbury; Sunbury Community Hosp.; '75-'76 Academic Year
(1) Postgraduate Medical Seminars; by **Hahnemann**, 2nd and 4th Wednesdays, Sept., Oct., Nov., Feb., March and Apr. (76-1-7)
Contact: Willard W. Christman, M.D., DME, Sunbury Community Hosp., Sunbury 17801

Titusville; Titusville Hosp.; '75-'76 Academic Year
(1) Continuing Education for Physicians, by **Pitt**, alternately at Titusville, Oil City, and Franklin; monthly, Oct.-June (76-1-67)
Contact: Robert M. Pilewski, M.D., Oil City Hosp., Oil City 16301

Uniontown; Fayette Co. Med. Soc.; '75-'76 Academic Year
(1) Continuing Education for Physicians; by **Pitt**, monthly, Sept.-Mar. (76-1-286)
Contact: Walter Lion, Exec. Sec., Fayette Co. Med. Soc., Uniontown 15401

Warren; **Warren State**, '75-'76 Academic Year
(1) Guest Lecturer Program; by Western Psychiatric Inst.; monthly, July 1-June 30, 1976; Fridays and Saturdays (76-1-30)
(1) Psychiatric Film Seminar; Mondays, July 7-June 30 (except holidays) (76-1-10)
(1) Literature Seminar; Thursdays (except holidays) July 3-June 25 (76-1-11)
Contact: Leonard H. Brennan, M.D., DME, **Warren State**

Washington; **Washington** Hosp.; 1975
(1) Clinical Therapeutics and Pharmacology; Wednesdays, Oct. 1, 15, 22 and 29 (75-2-20)
(1) Current Concepts in Diabetes Mellitus; Wednesdays, Nov. 5, 19 and 26 (75-2-86)
Contact: Jon Adler, M.D., Chrm., Staff Educ. Comm., **Washington**

Wellsboro; Soldiers and Sailors Mem. Hosp.; '75-'76 Academic Year
(1) Postgraduate Seminars for Physicians; by **Jefferson**, Oct. 15-June 16, third Wednesdays; (except December) (76-1-8)
Contact: James L. Wilson, M.D., Chrm., Cont. Educ. Comm., Soldiers and Sailors Mem. Hosp., Wellsboro, 16901

Wernersville; Wernersville St. Hosp.; '75-'76 Academic Year
(1) Continuing Education for Psychiatrists; by **Institute;** weekly, Oct., Jan., Mar. and Apr. (76-1-282)
Contact: Ronald A. Ivison, Ed.D., Ass't. Dir., Clin. Educ., Wernersville State Hosp., Wernersville 19565

Wilkes-Barre; Luzerne Co. Med. Soc.; 1975
(1) Postgraduate Seminars for Physicians; by **Jefferson**, second Wednesday, Feb.-Nov. (except July and Aug.) (75-2-21)
Contact: William Grossman, M.D., Chrm., Educ. Prgm., Luzerne Co. Med. Soc., 130 S. Franklin St., Wilkes-Barre 18701

Wilkes-Barre; Mercy Hosp.; 1975
(1) Continuing Education Program; by **Geisinger**, Sept. 25; Oct. 9; Oct. 16; Nov. 13 (75-2-87)
Contact: J.P. Brennan, M.D., DME, Mercy Hosp., 196 Hanover St., Wilkes-Barre 18703

Wilkes-Barre; Wilkes-Barre Gen. Hosp.; '75-'76 Academic Year
(1) Rheumatoid Arthritis Clinic; by **Hahnemann**, third Fridays each month (75-2-30)
(1) Medical Department Audiovisual Presentations; by **Hahnemann**, first Thurs. ea. month except July (76-1-29)
Contact: Lester M. Saidman, M.D., DME, Wilkes-Barre Gen. Hosp., River & Auburn Sts., Wilkes-Barre 18702

Wilkes-Barre; Wyoming Valley Hosp.; '75-'76 Academic Year
(1) Continuing Education Program; by **Hahnemann**; Wednesdays, Sept. 10-May 19 (76-1-283)
Contact: Robert J. Schaefer, Exec. Dir., Cont. Educ., **Hahnemann**

Williamsport; Williamsport Hosp.; '75-'76 Academic Year
(1) Continuing Education Program; by **U. of Pa.**; Sept. 5-Dec. 20 (75-2-88)
(1) Williamsport Seminars; by **U. of Pa.**; second Fri., Sept. 12-June 11 (76-1-9)
Contact: Herman W. Rannels, M.D., Vice President and Med. Dir. Williamsport Hosp., 777 Rural Ave., Williamsport 17701

York; **York Hosp.** '75-'76 Academic Year
(1) Continuing Education Program; weekly, Sept. 4-Apr. 29 (76-1-300)
Contact: David M. Shearer, M.D., Coordinator, Dept. of Med., **York**

Other C.M.E. Opportunities

Pa. Steering Comm. on Cont. Educ. for Phys. in Psychiatry — Contact: Benjamin Schneider, M.D., Chrm., through the office of the Pa. Acad. of Family Phys., 5600 Derry St., Harrisburg, Pa. 17111 Tel: (717) 564-5365.

CALENDAR

, quick reference to Category One continuing medical ducation opportunities in Pennsylvania by date.

SEPTEMBER

2 Human Sexuality; at Woodville St. Hosp., Carnegie (75-2-1)
2 Modern Approach to Allergic Disease; by Lawrence Co. Med. Soc., New Castle (76-1-82)
2 An Overview of Our Health Care System; at Citizens Gen. Hosp., New Kensington (75-2-29)
3 Complex Biliary Surgery with Emphasis on Diagnostic Considerations; at Latrobe Area Hosp. (76-1-297)
3 Radioisotope Scans; Tri-Co. Branch Med. Soc., Natrona Heights (75-2-24)
4 Somatopsychic Aspects of Endocrine Dosorders; at Pottsville Hosp. (76-1-6)
4 Asymptomatic Gallstones; at Wilkes-Barre Gen. Hosp. (76-1-29)
4-6 Pulmonary Physiology and Medicine; at St. Francis, Pittsburgh (75-2-31)
5 Head Injuries, An Approach; at Frankford, Philadelphia (76-1-299)
5 Misinterpretation of Laboratory Findings; Philadelphia St. Hosp. (76-1-160)
5-6 Pediatrics; at Williamsport Hosp. (75-2-88)
9-12 • Family Medicine Refresher Course; at M.S. Hershey, Hershey (75-2-107)
9 Practical Management of Common Neurological Problems; at Mayview St. Hosp., Bridgeville (76-1-12)
9 Human Sexuality; at Woodville St. Hosp., Carnegie (75-2-1)
9 Thyroid Function Studies; at Lancaster Gen. Hosp., Lancaster (76-1-76)
9-10 • Child Abuse; at M.S. Hershey (75-2-28)
9 Hypertension; at Jameson Mem. Hosp., New Castle (76-1-80)
0 Recent Advances in Evaluation and Treatment of Right and Left Congestive Heart Failure; at Allentown-Sacred Heart Hosp. (76-1-34)
0 Continuing Care of Long-Term Patients; at Luzerne Co. Med. Soc., Wilkes-Barre (75-2-21)
0 Acute Abdomen: Diagnosis and Management; at Sunbury Community Hosp. (76-1-7)
0 Office Otology-Vertigo; at Wyoming Valley Hosp., Wilkes-Barre (76-1-283)
1 Diagnosis and Management of G.I. Bleeding; at Nesbitt Mem. Hosp., Kingston (76-1-71)
2 Blood Component Therapy; at Frankford, Philadelphia (76-1-299)
2 Phaco-Emulsification Surgery for Cataract; Philadelphia St. Hosp. (76-1-160)
2 Differential Diagnosis of Muscle Diseases; at Williamsport Hosp. (76-1-9)
2-13 Heart Failure and Heart Murmurs; by AHA, Hershey (75-2-127)
2-13 OB/GYN; at Williamsport Hosp. (75-2-88)
5 Hematological Work-Up; at Bradford (76-1-416)
5 Human Sexuality; at Woodville St. Hosp., Carnegie (75-2-1)
5 Continuing Education Program; at Lancaster Gen. Hosp., Lancaster (76-1-76)
5 Regional Ileitis and Ulcerative Colitis; at Monongahela Valley Hosp., Monongahela (76-1-42)
6 Acute Abdomen; at St. Francis Hosp., New Castle (76-1-80)
6 Symptoms and Signs of Uremia; at Mem. Hosp. of Roxborough, Philadelphia (75-2-91)
7 Rheumatoid Arthritis: Diagnosis and Treatment for the Practitioner; at Geisinger, Danville (76-2-34)
7 Generic vs. Brand Name Drugs; at Wyoming Valley Hosp., Wilkes-Barre (76-1-283)
7-20 Microneurosurgery of the Cranial Nerves; at Pitt (75-2-65)
7 Coronary Artery Diseases; at St. John's Gen. Hosp., Pittsburgh (76-1-251)
8 Hypertension; at Harrisburg Hosp. (76-1-2)
8 Sciatica and Low Back Pain; at Hazleton St. Gen. Hosp. (76-1-4)
8 Quality Control of Nuclear Medicine; at M.S. Hershey, Hershey (75-2-113)
8-21 Family Medicine, a Refresher Course and Practice Examination for Family Physicians; by Pitt (75-2-66)
9 Urology-Urological Emergencies; at Bryn Mawr Hosp. (76-1-38)
9 Hypertension—Workup and Evaluation; at Frankford, Philadelphia (76-1-299)
9 • Scientific Meeting; at Colon & Rectal, Philadelphia (76-1-3)
9 Mercy Day Scientific Conference; at Pittsburgh Mercy (75-2-4)
9-20 Sexual Dysfunction: When to Counsel, When to Refer; by Pitt (75-2-90)
9-20 Medicine; at Williamsport Hosp. (75-2-88)
9-21 • Advances in Dermatology: 1975; Dermatology, Hershey (75-2-2)
0 Clinical Nutrition Symposium; at M.S. Hershey, Hershey (75-2-104)
2-24 Sports Medicine; by Hahnemann, Philadelphia (75-2-51)
2-26 • Introductory Diagnostic Ultrasound; Episcopal Hosp., Philadelphia (76-1-122)
22-26 Mechanisms and Therapy of Cardiac Arrhythmias; Lankenau Hosp., Philadelphia (75-2-89)
23 ABC's of Acid Base Balance; at Memorial Hosp. of Roxborough, Philadelphia (75-2-91)
23 Human Sexuality; at Woodville St. Hosp., Carnegie (75-2-1)
24 Recent Advances in Diabetes; at Allentown-Sacred Heart Hosp. (76-1-34)
24 Hyperalimentation; at North Penn Hosp., Lansdale (76-1-79)
24 Hyper and Hypocalcemic Syndromes; at Holy Redeemer Hosp., Meadowbrook (76-1-14)
24 Update on Use of Blood Products; at North Hills Passavant Hosp., Pittsburgh (76-1-233)
24 Diagnosis and Management of Acute Renal Failure; at Sunbury Community Hosp. (76-1-7)
24 Peptic Ulcer Disease-Hepatitis; at Wyoming Valley Hosp., Wilkes-Barre (76-1-283)
24-26 Basic Electrocardiography; at M.S. Hershey, Hershey (75-2-105)
25 Diagnosis and Management of Renal Diseases; at Gettysburg (75-2-25)
25 Alcoholism—the Medical Management; at Hazleton St. Gen. Hosp. (76-1-4)
25 Shock: Post-Surgical; at Good Samaritan Hosp., Pottsville (76-1-5)
25 Hyperalimentation; at Mercy Hosp., Wilkes-Barre (75-2-87)
25-28 Diseases Due to Immune Mechanisms; by Pitt (75-2-22)
25-Oct. 2 • Cultural Anthropology for Psychiatrists; at EPPI, Philadelphia (75-2-44)
26 Hyperalimentation; at Frankford, Philadelphia (76-1-299)
26 Drug Induced Lupus; Philadelphia St. Hosp. (76-1-160)
26-27 Surgery; at Williamsport Hosp. (75-2-88)
29-Oct. 2 An Electrophysiological Approach to Diagnosis and Treatment of Cardiac Arrhythmias; by ACP, Philadelphia (75-2-115)
29-Oct. 2 International Conference on Neural Control of Locomotion; by Temple, Philadelphia (75-2-58)
30 Human Sexuality; at Woodville St. Hosp., Carnegie (75-2-1)
30 Hypertension; at Lancaster Gen. Hosp., Lancaster (76-1-76)
30 Breast Carcinoma; at St. Francis Hosp., New Castle (76-1-81)
30 Proteinuria/Hemodialysis versus Transplantation; at Mem. Hosp. of Roxborough, Philadelphia (75-2-91)

OCTOBER

1 Altered States of Consciousness; at Geisinger, Danville (75-2-35)
1 Venereal Diseases - Diagnosis and Treatment; at Easton Hosp. (76-1-65)
1 Pregnancy—The Problems Related to other Illnesses; at Latrobe Area Hosp. (76-1-297)
1 Urology—Emphasis on Recurrent Urinary Tract Infections in Women; Tri-Co. Branch Med. Soc., Natrona Heights (75-2-24)
1 Clinical Therapeutics and Pharmacology; at Washington Hosp. (75-2-20)
1 Inflammatory Diseases of Colon-Differential Diagnosis of Jaundice; at Wyoming Valley Hosp., Wilkes Barre (76-1-283)
1-3 Review Course in Family Medicine; Jefferson, Philadelphia (75-2-100)
2 Tumors of the Stomach; at Hazleton St. Gen. Hosp. (76-1-4)
2 Pre- & Post-Operative Medical Evaluation and Management; at Lancaster Osteopathic Hosp. (76-1-78)
2 Prevention and Treatment of Thrombo-Embolism; at Pottsville Hosp. (76-1-6)
2 Chest Pain and Fever; at Wilkes-Barre Gen. Hosp. (76-1-29)
2-4 • Advances in Management of Fetus and Newborn; by M.S. Hershey, Hershey (75-2-11)
3 Acid Base Balance; at McKeesport Hosp. (75-2-41)
3 Cardiomyopathies; at Frankford, Philadelphia (76-1-299)
3-4 Emergencies in the Home; Children's Hosp., Pittsburgh (75-2-69)
3-4 OB/GYN; at Williamsport Hosp. (75-2-88)
4 Introduction to Transactional Analysis; at Family Guidance Center, Reading (75-2-39)
7 Human Sexuality; at Woodville St. Hosp., Carnegie (75-2-1)
7 The Patient With Hyperlipidemia; at Lancaster Gen. Hosp., Lancaster (76-1-76)
7 Diagnosis and Treatment of Lower Back Pain; by Lawrence Co. Med. Soc., New Castle (76-1-82)
7 Management of Hypertension; at Mem. Hosp. of Roxborough, Philadelphia (75-2-91)

KEY:

• Indicates session that will be presented at a specialty level.

(75-1-XX) Numbers in parentheses are Code numbers which refer to specific items in the "Announcement" section of this supplement. See: town, institution, and code numbered item for complete details.

8 Indications of Patients Needing Further Psychiatric Care; at Allentown-Sacred Heart Hosp. (76-1-34)
8 Pre and Post-Operative Medical Evaluation and Management; at Sunbury Community Hosp. (76-1-7)
8 Failure to Thrive in Infancy; at Luzerne Co. Med. Soc., Wilkes-Barre (75-2-21)
8 Chronically Ill Child/Hyperactive Child; at Wyoming Valley Hospital., Wilkes-Barre (76-1-283)
8-10 New Concepts in Basic and Applied Hematology; at Jefferson, Philadelphia (75-2-116)
8-10 Infection and Infection Controls in the Hospital and Health Care Facilities; by Pitt (75-2-70)
9 Arteriosclerosis; Atherosclerosis; at Hazleton St. Gen. Hosp. (76-1-4)
9 Rapid Treatment of Sexual Dysfunction (Masters & Johnson); Hershey (75-2-92)
9 The Child Problem Diabetic; at Nesbitt Mem. Hosp., Kingston (76-1-71)
9 Jaundice: Differential Diagnosis and Management; at Lancaster Osteopathic Hosp. (76-1-78)
9 Psychopharmacology Update; at Wernersville St. Hosp. (76-1-282)
9 Drugs and Liver Disease; at Mercy Hosp., Wilkes-Barre (75-2-87)
9-12 Second Annual Temple Conference on Behavior Therapy and Behavior Modification; by Temple, Philadelphia (75-2-62)
10 Renal Physiology and Its Relationship to Renal Function and Hypertension; at McKeesport Hosp. (75-2-41)
10 Common Office Gynecologic Problems and Their Treatment; at Frankford, Philadelphia (76-1-299)
10 Edema Formation Mechanisms; Philadelphia St. Hosp. (76-1-160)
10 Surgery in Rheumatoid Arthritis; at Williamsport Hosp. (76-1-9)
10-11 Pediatrics; at Williamsport Hosp. (75-2-88)
10-12 Football Sports Medicine Weekend; at Coll. of Phys./Philadelphia (75-2-60)
11 First Annual Weiss-English Psychosomatic Program; at Temple, Philadelphia (75-2-56)
13-15 Acid-Base and Electrolyte Balance; by Hahnemann, Philadelphia (75-2-53)
14 Parkinson's Disease; at Mayview St. Hosp., Bridgeville (76-1-12)
14 Human Sexuality; at Woodville St. Hosp., Carnegie (75-2-1)
14 Nuclear Cardiology; at Lancaster Gen. Hosp., Lancaster (76-1-76)
14 Ulcers; Gastric and Duodenal; at St. Francis Hosp., New Castle (76-1-80)
14 Lymphoma—Radiotherapy; at Citizens Gen. Hosp., New Kensington (75-2-29)
15 • Treatment Approaches and Goals in Mental Health; at Coatesville VA (75-2-33)
15 Seminar on Emergency Medicine; at Geisinger, Danville (75-2-36)
15 Peripheral Neuropathy and Muscle Disease; at St. John's Gen. Hosp., Pittsburgh (76-1-251)
15 Clinical Therapeutics and Pharmacology; at Washington Hosp. (75-2-20)
15 Risks, including Malpractice in Radiology; at Soldiers and Sailors Mem. Hosp., Wellsboro (76-1-8)
15 Skin Tumors-Skin Manifestations of Internal Disease; at Wyoming Valley Hosp., Wilkes-Barre (76-1-283)
16 Periarteritis Nodosa and Lupus Erythematosis; at Hazleton St. Gen. Hosp. (76-1-4)
16 Neurological Complication of Visceral Malignancy; at Lancaster Osteopathic Hosp. (76-1-78)
16 Chronic Liver Failure; at Holy Redeemer Hosp., Meadowbrook (76-1-14)
16 Learning Disabilities; at Children's Hosp. of Phila. (75-2-43)
16 Psychopharmacology Update; at Wernersville St. Hosp. (76-1-282)
16 Update on Newer Antibiotics; at Mercy Hosp., Wilkes-Barre (75-2-87)
17 Correlated Clinical Science Course-Surgery; at Bryn Mawr Hosp. (76-1-38)
17 Physiology of Cellular Growth and Its Relationship to Management of Cancer; at McKeesport Hosp. (75-2-41)
17 Venereal Disease—An Update; at Frankford, Philadelphia (76-1-299)
17-18 Office Problems and How to Solve Them; at Pitt (75-2-73)
17-18 Medicine; at Williamsport Hosp. (75-2-88)
18 • Eating Disorders—Obesity and Anorexia Nervosa; at Norristown State (75-2-123)
18 Psychopharmacologic Agents in Primary Care Practice; at Packer, Sayre (75-2-85)
19-22 Clinical Skills for Physician Assistants III; by Hahnemann, Philadelphia (75-2-50)
20 Therapies for Sexual Dysfunction; at Bryn Mawr Hosp. (76-1-37)
20-24 • Advanced Workshop for Career Emergency Physicians; at M.S. Hershey, Hershey (75-2-106)
20-24 Diagnostic Ultrasound—Abdominal Scanning; Episcopal Hosp., Philadelphia (76-1-123)
20-31 Workshops in Respiratory Intensive Care; by Hahnemann, Philadelphia (76-1-145)
21 Thyroid Function Tests—Interpretations and Drug Interference; at Bradford (76-1-416)
21 Antibiotics I; at Bryn Mawr Hosp. (76-1-36)
21 Human Sexuality; at Woodville St. Hosp., Carnegie (75-2-1)
21 Diverticular Diseases of the Gastro-Intestinal Tract; at Monongahela Valley Hosp., Charleroi (76-1-42)
21 Continuing Education Program; at Lancaster Gen. Hosp., Lancaster (76-1-76)
21 The Jaundiced Patient; at Citizens Gen. Hosp., New Kensington (75-2-29)
21 Diuretics: Physiology, Pharmacology, and Site of Action; at Memorial Hosp. of Roxborough, Philadelphia (75-2-91)
21 Chamberlain Lecture; at Temple, Philadelphia (75-2-55)
22 Immune Problems in Gastro-Intestinal Diseases; at Allentown-Sacred Heart Hosp. (76-1-34)
22 Clinical Applications of Neural Physiology; at North Penn Hosp., Lansdale (76-1-79)
22 Drug Interactions; at Holy Redeemer Hosp., Meadowbrook (76-1-14)
22 Anemia and Liver Disease; at Sunbury Community Hosp. (76-1-7)
22 Clinical Therapeutics and Pharmacology; at Washington Hosp. (75-2-20)
22 Use & Abuse of Blood Fractions-Current Status of Chemotherapy; at Wyoming Valley Hosp., Wilkes-Barre (76-1-283)
23 Care of the More Common ENT Problems; at Gettysburg (75-2-25)
23 Diagnosis and Management of Common Skin Problems; at Gettysburg (75-2-25)
23 Management of the Trauma Patient; at Lancaster Osteopathic Hosp. (76-1-78)
23 Ultra Sound Diagnostic Procedures; at North Hills Passavant Hosp., Pittsburgh (76-1-233)
23 Human Sexuality; at Harrisburg, Polyclinic (76-1-2)
23 Psychotherapeutic Measures Useful in General Medical Practice; at Hazleton St. Gen. Hosp. (76-1-4)
23 Cutaneous Manifestations of Systemic Diseases; at Good Samaritan Hosp., Pottsville (76-1-5)
23 Psychopharmacology Update; at Wernersville St. Hosp. (76-1-282)
23-25 Phaco-Emulsification: Surgical Techniques; at Eye and Ear Hosp., Pittsburgh (75-2-72)
23-25 Practical Clinical Dermatology; by Pitt (75-2-74)
24 Clinical Immunology Tests; at Geisinger, Danville (75-2-37)
24 Infectious Diseases; at McKeesport Hosp. (75-2-41)
24 Acute Gastro-Intestinal Hemorrhage; at Frankford, Philadelphia (76-1-299)
24 Hemoglobinopathies; Philadelphia St. Hosp. (76-1-160)
24-25 Surgery; at Williamsport Hosp. (75-2-88)
24-26 The Many Faces of Alcoholism; at Pitt (75-2-71)
28 Human Sexuality; at Woodville St. Hosp., Carnegie (75-2-1)
28 Adenocarcinoma of Large Intestine; at St. Francis Hosp., New Castle (76-1-81)
28 Urinary Tract Infections; at Memorial Hosp. of Roxborough, Philadelphia (75-2-91)
29 Clinical Therapeutics and Pharmacology; at Washington Hosp. (75-2-20)
29 Office Ophthalmology; at Wyoming Valley Hosp., Wilkes-Barre (76-1-283)
30 Pancreaticoduodenal Tumors; at Hazleton St. Gen. Hosp. (76-1-4)
30 Diagnosis and Treatment of Gastrointestinal Hemorrhage; at Lancaster Osteopathic Hosp. (76-1-78)
30 Psychopharmacology Update; at Wernersville St. Hosp. (76-1-282)

31 Endocrinology; at McKeesport Hosp. (75-2-41)
31 Fever of Unknown Origin; at Frankford, Philadelphia (76-1-299)
31 Diabetic Foot: Philadelphia St. Hosp. (76-1-160)
31-Nov. 1 Community Medicine; at Williamsport Hosp. (75-2-88)

NOVEMBER

1 The Third Ob-Gyn Anesthesia Symposium; at Pitt (75-2-83)
2-8 Surgical Anatomy and Techniques of Temporal Bone; Eye and Ear Hosp., Pittsburgh (75-2-77)
3-4 Use of Staplers in Surgery; at Pitt. (75-2-76)
4 Human Sexuality; at Woodville St. Hosp., Carnegie (75-2-1)
4 The Management of the Patient with Headache; at Lancaster Gen. Hosp., Lancaster (76-1-76)
4 What's New in Rheumatology; by Lawrence Co. Med. Soc., New Castle (76-1-82)
5 • Scientific Meeting; by Colon & Rectal, Harrisburg (75-2-26)
5 Role of Medical Director in Skilled Nursing Facility; by PMS, Harrisburg (75-2-295)
5 Urinary Tract Infections; at Latrobe Area Hosp. (76-1-297)
5 Diabetes; at Nazareth Hosp., Philadelphia (75-2-54)
5 Jaundice: Differential Diagnosis and Management; at Sunbury Community Hosp. (76-1-7)
5 Current Concepts in Diabetes Mellitus; at Washington Hosp. (75-2-86)
6 Coping With Change; by PMS, Harrisburg (75-2-94)
6 • Scientific Program; by Plastic Surgery, Harrisburg (75-2-103)
6 Cancer of the Skin and Precancerous Lesions of the Skin and Oral Cavity; at Hazleton St. Gen. Hosp. (76-1-4)
6 Newer Tests for Peripheral Vascular Disease; at Lancaster Osteopathic Hosp. (76-1-78)
6 Bloody Stools; at Pottsville Hosp. (76-1-6)
6 Pulmonary Thromboembolism; at Wilkes-Barre Gen. Hosp. (76-1-29)
6-7 Scientific Program; by Orthopaedics; Harrisburg (75-2-96)

7 • Scientific Program, by Allergy; Harrisburg (75-2-101)
7 Scientific Program; Pa. Soc. of Internal Med.; Harrisburg (75-2-128)
7 • Diabetic Complications Encountered in Rehabilitation; by Physical Med. and Rehabilitation, Harrisburg (75-2-97)
7 • Scientific Program, by Surgery; Harrisburg (75-2-102)
7 Use and Abuse of Psychotropic Chemicals; Psychiatry, Harrisburg (75-2-98)
7 Pulmonary Physiology and Its Relationship to Management of Pulmonary Disorders at McKeesport Hosp. (75-2-41)
7 Metabolic Bone Disease; at Frankford, Philadelphia (76-1-299)
7-8 Bone Marrow Biopsy for Pathologists; at Pitt. (75-2-79)
7-8 Pediatrics; at Williamsport Hosp. (75-2-88)
0-21 • Chevalier Jackson Basic Course in Bronchoesophagology; at Temple, Philadelphia (76-1-203)
1 Management of Head Injuries; at Mayview St. Hosp., Bridgeville (76-1-12)
1 Obesity; at Lancaster Gen. Hosp., Lancaster (76-1-76)
1 Heart Murmurs—How to Evaluate; at Jameson Mem. Hosp., New Castle (76-1-80)
1 GI Emergencies; at Citizens Gen. Hosp., New Kensington (75-2-29)
2 Immune Problems in Respiratory Diseases; at Allentown-Sacred Heart Hosp. (76-1-34)
2 Diagnosis and Management of Common Pulmonary Problems; at Geisinger, Danville (75-2-38)
2 Iatrogenesis; at Holy Redeemer Hosp., Meadowbrook (76-1-14)
2 Radiology in the Emergency Department; at Temple, Philadelphia (75-2-63)
2 Changing Concepts in the Treatment of Diabetes; at Luzerne Co. Med. Soc., Wilkes-Barre (75-2-21)
2-14 Endocrine Therapeutics in Practice; at Jefferson, Philadelphia (75-2-114)
3 Hodgkin's Disease and Lymphosarcoma; at Hazleton St. Gen. Hosp. (76-1-4)
3 Treatment of Severe Asthmatics: child and adult; at Nesbitt Mem. Hosp., Kingston (76-1-71)
3 Ultrasonic Techniques in Medical Diagnosis; at Lancaster Osteopathic Hosp. (76-1-78)
3 Headache; at Mercy Hosp., Wilkes-Barre (75-2-87)
3-14 Seminar and Workshop in Diagnostic and Operative Laparoscopy; Magee-Women's Hosp., Pittsburgh (75-2-80)
3-15 Gynecologic Oncology Seminar; at M.S. Hershey, Hershey (75-2-108)
4 Physiology of the GI Tract and Its Relationship to GI Symptoms; at McKeesport Hosp. (75-2-41)
4 Management of Cardio-Pulmonary Arrest; at Frankford, Philadelphia (76-1-299)
4 Cardiac Surgery—An Internist's View; Philadelphia St. Hosp. (76-1-160)
4 Trauma; at Pitt (75-2-82)
4 Structural Heart Disease; at Williamsport Hosp. (76-1-9)
4-15 Endocrine Symposium; at Coll. of Phys./Philadelphia (75-2-64)
4-15 OB/GYN; at Williamsport Hosp. (75-2-88)
5 Clinical Concepts of Shock; by Lehigh AHEC, Bethlehem (75-2-40)
5 Alone, Abandoned and Afraid; at M.S. Hershey, Hershey (75-2-109)
5 Medicine Postgraduate Day; at Packer, Sayre (75-2-84)
7 Modern Concepts in Evaluation and Management of Pelvic Malignancy; by Temple, Philadelphia (75-2-59)
7-21 Diagnostic Ultrasound—Echocardiography; Episcopal Hosp., Philadelphia (76-1-124)
8 Antibiotics—Mechanism of Action and How to Select; at Bradford (76-1-416)
8 Antibiotics II; at Bryn Mawr Hosp. (76-1-36)
8 Continuing Education Program; at Lancaster Gen. Hosp., Lancaster (76-1-76)
8-19 Establishing Yourself in Medical Practice; by PMS, Harrisburg (75-2-99)
8 Mediterranean Anemia (Thalassemia); at Monongahela Valley Hosp., Monongahela (76-1-42)
8 Hodgkin's Disease—Lymphomas; at St. Francis Hosp., New Castle (76-1-81)
9 Recent Aspects of Neurologic Therapies—1975 Annual Symposium; at Jeanes, Philadelphia (75-2-122)
9 Laboratory—New Tests and Significance; at St. John's Gen. Hosp., Pittsburgh (76-1-251)
9 Blood Gases: Evaluation and Utilization; at North Hills Passavant Hosp., Pittsburgh (76-1-233)
9 Drug Interaction and Hypersensitivity; at Sunbury Community Hosp. (76-1-7)
9 Current Concepts in Diabetes Mellitus; at Washington Hosp. (75-2-86)
9 Orthopaedic Aspects of Sports Medicine; at Soldiers and Sailors Mem. Hosp., Wellsboro (76-1-8)
0 Neurology and Neuromuscular Abnormalities; at Harrisburg Hosp. (76-1-2)
0 Eczema Including Seborrheic Dermatitis; at Hazleton St. Gen. Hosp. (76-1-4)
0 Pediatric Gynecology; at Lancaster Osteopathic Hosp. (76-1-78)
0 Diabetes Symposium; by Pitt (75-2-81)
0 Symposium on Diagnosis and Treatment of Rheumatoid Arthritis; at Good Samaritan Hosp., Pottsville (76-1-5)
20-21 Medicine, at Williamsport Hosp. (75-2-88)
21 Correlated Clinical Science Course-Surgery; at Bryn Mawr Hosp. (76-1-38)
21 Physiology of the Heart and Its Relationship to Heart Failure; at McKeesport Hosp. (75-2-41)
21 Complications in the Post Operative Patient; at Frankford, Philadelphia (76-1-299)
23-25 Electrocardiography for Practitioner; by Hahnemann, Philadelphia (75-2-49)
26 Immune Problems in Renal Diseases; at Allentown-Sacred Heart Hosp. (76-1-34)
26 Management of Congestive Heart Disease; at North Penn Hosp., Lansdale (76-1-79)
26 Pathophysiology and Management of Shock; at Holy Redeemer Hosp., Meadowbrook (76-1-14)
26 Current Concepts in Diabetes Mellitus; at Washington Hosp. (75-2-86)
28-29 Surgery; at Williamsport Hosp. (75-2-88)

DECEMBER

2 Continuing Education Program; at Lancaster Gen. Hosp., Lancaster (76-1-76)
3 Headaches: Differential Diagnosis and Treatment, at Easton Hosp. (76-1-65)
3 Office Procedures in Family Practice Setting, at Latrobe Area Hosp. (76-1-297)
4 Neurovascular Syndromes of the Shoulder Girdle; at Hazleton St. Gen. Hosp. (76-1-4)
4 Disorders of Menstruation; at Lancaster Osteopathic Hosp. (76-1-78)
4 Venereal Disease; at Pottsville Hosp. (76-1-6)
4 Coronary Artery Disease Surgery; at Wilkes-Barre Gen. Hosp. (76-1-29)
5 Pneumonias; at Frankford, Philadelphia (76-1-299)
5-6 Pediatrics; at Williamsport Hosp. (75-2-88)
9 Evaluation of the Comatose Patient; at Mayview St. Hosp., Bridgeville (76-1-12)
9 Reappraisal of the Pill; at Lancaster Gen. Hosp., Lancaster (76-1-76)
9 Diabetes; at St. Francis Hosp., New Castle (76-1-80)
10 Phases in Adult Life with Predictable Crises; at Allentown-Sacred Heart Hosp. (76-1-34)
10 Immunoglobulin Deficiency Syndromes; at Holy Redeemer Hosp., Meadowbrook (76-1-14)
11 Fractures of the Hip; at Hazleton St. Gen. Hosp. (76-1-4)
11 Management of Hemorrhagic Disorders; at Lancaster Osteopathic Hosp. (76-1-78)
12 New Methods of Cancer Treatment; at M.S. Hershey, Hershey (75-2-110)
12 Clinical Application of Renin and Aldosterone Measurements; at Frankford, Philadelphia (76-1-299)
12 New Therapies for Common Skin Manifestations of GI Disease; Philadelphia St. Hosp. (76-1-160)
12 Diagnosis and Treatment of Depression in a General Medical Practice; at Williamsport Hosp. (76-1-9)
12-13 OB/GYN; at Williamsport Hosp. (75-2-88)
15-19 • Introductory Diagnostic Ultrasound; Episcopal Hosp., Philadelphia (76-1-122)
15 Quality Review in Psychiatry; at Bryn Mawr Hosp. (76-1-37)
16 Kidney Drugs - Diuretics; at Bryn Mawr Hosp. (76-1-36)
16 Vertigo; at Monongahela Valley Hosp., Charleroi (76-1-42)
16 Diagnosis & Treatment of Patient with Herniated Lumbar Disc., at Lancaster Gen. Hosp., Lancaster (76-1-76)
16 Primary Ovarian Carcinoma; at St. Francis Hosp., New Castle (76-1-81)
16 Alcoholism—1975; at Citizens Gen. Hosp., New Kensington (75-2-29)
17 Pre & Post Op evaluation of the cardio respiratory system; at North Penn Hosp., Lansdale (76-1-79)
17 Hypertension; at St. John's Gen. Hosp., Pittsburgh (76-1-251)
18 Obesity; at Hazleton St. Gen. Hosp. (76-1-4)
18 Inflammatory Bowel Disease in Children; at Lancaster Osteopathic Hosp. (76-1-78)
18 Fluid and Electrolyte Problems in Surgical Patients; at Good Samaritan Hosp., Pottsville (76-1-5)
19-20 Medicine; at Williamsport Hosp. (75-2-88)
19 Gastroesophageal Reflux; at Bryn Mawr Hosp. (76-1-38)
19 The Colitis Problem; at Frankford, Philadelphia (76-1-299)

JANUARY

5-9 Workshops in Physiology, Diagnosis and Treatment of Electrolyte and Acid-Base Disorders; at U. of Pa., Philadelphia (76-1-336)
6 Blood and Its Derivatives; by Lawrence Co. Med. Soc., New Castle (76-1-82)
7 More Common Disturbances of Electrolyte Balance; at Latrobe Area Hosp. (76-1-297)
8 Pheochromocytoma; at Hazleton St. Gen. Hosp (76-1-4)

8 Concept of Pre-Diabetes; at Lancaster Osteopathic Hosp. (76-1-78)
8 Acute Respiratory Failure: Diagnosis and Treatment; at Nesbitt Mem. Hosp., Kingston (76-1-71)
8 Pancreatic Diseases; at Pottsville Hosp. (76-1-6)
9 An Approach to Anticoagulating Your Patient—Hospital and Office; at Frankford, Philadelphia (76-1-299)
9 New Diagnostic Techniques in Radiology—Part II; Philadelphia St. Hosp. (76-1-160)
9 Practical Issues in Law for Psychiatrists; at Wernersville St. Hosp. (76-1-282)
9 Drug Abuse; at Williamsport Hosp. (76-1-9)
11 Hepatitis; at Allentown-Sacred Heart Hosps. (76-1-34)
12-16 Diagnostic Ultrasound—Abdominal Scanning; Episcopal Hosp., Philadelphia (76-1-123)
13 Evaluation of the Patient with Chest Pain; at Mayview St. Hosp., Bridgeville (76-1-12)
13 Disorders of the Adrenals—Diagnostic Approaches; at Jameson Mem. Hosp., New Castle (76-1-80)
14 Hepatitis; at Allentown-Sacred Heart Hosp. (76-1-34)
14 Clinical Implications of New Discovered Hormonal Agents; at Holy Redeemer Hosp., Meadowbrook (76-1-14)
15 Cancer of the Rectum and Anus; at Hazleton St. Gen. Hosp. (76-1-4)
15 Evaluation of Patients with Heart Disease by Non-Invasion Technique; at Lancaster Osteopathic Hosp. (76-1-78)
16 Pathophysiologic Changes with Pancreatic Disease; at Bryn Mawr Hosp. (76-1-38)
16 • Scientific Meeting; at Colon & Rectal, Philadelphia (76-1-3)
16 The Solution is Problem—What Intravenous Solution to Use; at Frankford, Philadelphia (76-1-299)
16 Practical Issues in Law for Psychiatrists; at Wernersville St. Hosp. (76-1-282)
20 Psychic Drugs; at Bryn Mawr Hosp. (76-1-36)
20 Management of Head and Neck Cancer; at Monongahela Valley Hosp., Monongahela (76-1-42)
20 Leukemias; at St. Francis Hosp., New Castle (76-1-81)
21 Management of Rheumatoid Arthritis; at St. John's Gen. Hosp., Pittsburgh (76-1-251)
21 Diagnosis and Management of Anemias; at Soldiers and Sailors Mem. Hosp., Wellsboro (76-1-8)
22 Treatment of Chronic Rheumatic Heart Disease; at Hazleton St. Gen. Hosp. (76-1-4)
22 Enzyme Changes in Malignant Tissues; at Lancaster Osteopathic Hosp. (76-1-78)
22 Radioisotopes in Clinical Hematology; at Holy Redeemer Hosp., Meadowbrook (76-1-14)
22 New Theories in Immunology; at North Hills Passavant Hosp., Pittsburgh (76-1-233)
22 Diagnosis and Management of Neuroses; at Good Samaritan Hosp., Pottsville (76-1-5)
22-24 Phaco-Emulsification: Surgical Techniques; Eye and Ear Hosp., Pittsburgh (76-1-238)
23 Pulmonary Emboli—1975; at Frankford, Philadelphia (76-1-299)
23 Management of Gout; Philadelphia St. Hosp. (76-1-160)
23 Practical Issues in Law for Psychiatrists; at Wernersville St. Hosp. (76-1-282)
24 • The Pulmonary Patient Undergoing Anesthesia and Surgery; at Packer, Sayre (76-1-25)
26-30 Concepts in Soft Tissue Surgery; at Pittsburgh Mercy (76-1-227)
28 Calcium Diseases; at Allentown-Sacred Heart Hosp. (76-1-34)
28 Reproductive Endocrinology; at North Penn Hosp., Lansdale (76-1-79)
28 Chest Radiology of Interest to Clinicians; at Holy Redeemer Hosp., Meadowbrook (76-1-14)
28-30 Update in Infectious Diseases; by ACP, Philadelphia (76-1-337)
29 Trichinosis; Tapeworms; at Hazleton St. Gen. Hosp. (76-1-4)
29 Continuing Education Program; at Lancaster Osteopathic Hosp. (76-1-78)
30 An Approach to the Achy Joint; at Frankford, Philadelphia (76-1-299)
30 Psychopharmacology; Philadelphia St. Hosp. (76-1-161)

FEBRUARY

2-13 • Chevalier Jackson Basic Course in Bronchoesophagology; at Temple, Philadelphia (76-1-203)
2-4 Endocrinology and Diabetes; by Hahnemann, Philadelphia (76-1-150)
3 Therapy in Geriatric Patients; by Lawrence Co. Med. Soc., New Castle (76-1-82)
4 Glomerulonephritis and Other Glomerulopathies; at Latrobe Area Hosp. (76-1-297)
5 Peptic Ulcer; at Hazleton St. Gen. Hosp. (76-1-4)
5 Conservative Management of Pregnancy Complicated by Diabetes; at Holy Redeemer Hosp., Meadowbrook (76-1-14)
5 Surgical Treatment of Impending Myocardial Infarction; at Pottsville Hosp. (76-1-6)
6 Which Patient Needs Dialyzed; at Frankford, Philadelphia (76-1-299)
8-14 Anatomy and Surgery of the Nose; Eye and Ear Hosp., Pittsburgh (76-1-239)
9-13 Diagnostic Ultrasound—Echocardiography; Episcopal Hosp., Philadelphia (76-1-124)
10 Cardio-Pulmonary Resuscitation; at St. Francis Hosp., New Castle (76-1-80)
11 Hair; at Allentown-Sacred Heart Hosp. (76-1-34)
12 Carcinoma of the Cervix; at Hazleton St. Gen. Hosp. (76-1-4)
12 Troubled Adolescence; at Nesbitt Mem. Hosp., Kingston (76-1-71)
13 Muscle Disease vs. Neurological; at Frankford, Philadelphia (76-1-299)
13 Psychopharmacology; Philadelphia St. Hosp. (76-1-161)
13 Endocrinology; at Williamsport Hosp. (76-1-9)
14-15 Advances in Clinical Practice, 1976; at Geisinger, Danville (76-1-15)
16 Research in Family Psychiatry; at Bryn Mawr Hosp. (76-1-37)
17 Immunological Therapeutics; at Bryn Mawr Hosp. (76-1-36)
17 Immunologic Tests and Interpretations; at Monongahela Valley Hosp., Charleroi (76-1-42)
17 Continuing Education for Physicians; at St. Francis Hosp., New Castle (76-1-81)
18 Pathophysiology of the GI Tract and Its Relationship to GI Symptoms; at Suburban Gen. Hosp., Pittsburgh (76-1-251)
18 Diagnosis and Treatment of Pulmonary Emphysema with Consideration of Occupational Hazards; at Soldiers and Sailors Mem. Hosp., Wellsboro (76-1-8)
19 Diabetes; at Harrisburg, Polyclinic (76-1-2)
19 Factors Concerned with Abnormal Coagulation and Thrombosis; at Hazleton St. Gen. Hosp. (76-1-4)
20 Correlated Clinical Science Course-Surgery; at Bryn Mawr Hosp. (76-1-38)
20 So the Patient is a "Little" Anemic; at Frankford, Philadelphia (76-1-299)
25 Acupuncture; at Allentown-Sacred Heart Hosp. (76-1-34)
25 Toxicology Poisoning & Overdose; at North Penn Hosp., Lansdale (76-1-79)
25 Coagulation Defects and Their Treatment; at Holy Redeemer Hosp., Meadowbrook (76-1-14)
25-27 Modern Therapeutics II; Jefferson, Philadelphia (76-1-293)
26 Carcinoma of the Esophagus; at Hazleton St. Gen. Hosp. (76-1-4)
26 Drug Therapeutics: Bio-availability and Interferences; at North Hills Passavant Hosp., Pittsburgh (76-1-233)
26 The Modern Management of Hip Fractures; at Good Samaritan Hosp., Pottsville (76-1-5)
27 Radiologic Potpourri-Some Interesting Cases; at Frankford, Philadelphia (76-1-299)
27 Biofeedback; Philadelphia St. Hosp. (76-1-161)

MARCH

1-5 Specifically Treatable Diseases; at Pennsylvania Hosp., Philadelphia (76-1-338)
2 Biliary and Pancreatic Disease; by Lawrence Co. Med. Soc., New Castle (76-1-82)
3 Hypothalamus in Health and Disease; at Latrobe Area Hosp. (76-1-297)
4 Early Detection of Heart Disease; at Hazleton St. Gen. Hosp. (76-1-4)
4 The Acute Allergic Reaction; at Holy Redeemer Hosp., Meadowbrook (76-1-14)
4 Modern Treatment of Coronary Artery Disease; at Pottsville Hosp. (76-1-6)
5 Pathologic Potpourri-Some Interesting Cases; at Frankford, Philadelphia (76-1-299)
6-7 • Vascular Diseases of the Ocular Fundus; at Wills Eye Hosp., Philadelphia (76-1-289)
8-12 • Introductory Diagnostic Ultrasound; Episcopal Hosp., Philadelphia (76-1-122)
9 Pulmonary Physiology and Its Relationship to Pulmonary Disorders; at Jameson Mem. Hosp., New Castle (76-1-80)
10 Ultra-Sound in the Diagnosis of Cardiac Diseases; at Allentown-Sacred Heart Hosp. (76-1-34)
11 Contact Dermatitis and Poison Ivy; at Hazleton St. Gen. Hosp. (76-1-4)
11 Behavioral Science for Family Practice; at Nesbitt Mem. Hosp., Kingston (76-1-71)
11-13 Phaco-Emulsification: Surgical Techniques; Eye and Ear Hosp., Pittsburgh (76-1-240)
12 • Scientific Meeting; at Colon & Rectal, Philadelphia (76-1-3)
12 A Review of the Fundus Oculi; at Frankford, Philadelphia (76-1-299)
12 Group Therapy; Philadelphia St. Hosp., (76-1-161)
12 Intercranial Pressure Monitoring; at Williamsport Hosp. (76-1-9)
13 • Surgical Postgraduate Day; at Packer, Sayre (76-1-276)
16 Cancer Therapy; at Bryn Mawr Hosp. (76-1-36)
16 Anti-arrhythmic Drugs; at Monongahela Valley Hosp., Monongahela (76-1-42)
17 Management of Diabetic Complications; at Geisinger, Danville (76-1-16)
17 Cancer of the Breast; at Suburban Gen. Hosp., Pittsburgh (76-1-251)
17 Use and Misuse of Antibiotics; at Soldiers and Sailors Mem. Hosp., Wellsboro (76-1-8)
18 Meningitis and Encephalitis; at Hazleton St. Gen. Hosp. (76-1-4)

8	Controversies in Social Psychiatry; at Wernersville St. Hosp. (76-1-282)
8-19	Frontiers of Psychotherapy; by Temple, Philadelphia (76-1-207)
9	Correlated Clinical Science Course-Surgery; at Bryn Mawr Hosp., (76-1-38)
9	Cancer Chemotherapy—An Update; at Frankford, Philadelphia (76-1-299)
4	Colonoscopy; at Allentown-Sacred Heart Hosp. (76-1-34)
4	Classification and Therapy of Immunologic Renal Disease; at Holy Redeemer Hosp., Meadowbrook (76-1-14)
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26-May 14	Second Career Training Program for Emergency Physicians; at Coll. of Phys./Philadelphia (76-1-113)
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5	Diagnosis and Treatment of Thyrotoxicosis; at Geisinger, Danville (76-1-20)
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27	Neurology in General Practice; at North Hills Passavant Hosp., Pittsburgh (76-1-233)
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Bedford Springs (76-1-417)
Lansdale, PAO&O (75-2-3)
Philadelphia; Coll. Phys./Phila. (76-1-167)
Philadelphia; Wills Eye Hosp. (76-1-289)

ORTHOPEDIC SURGERY
Harrisburg; Orthopaedics (75-2-96)
Hershey; M.S. Hershey (76-1-327)
Philadelphia; Albert Einstein Med. Cntr. (Northern) (76-2-3)
Philadelphia; Coll. Phys./Phila. (75-2-60)
Philadelphia; Temple (76-1-169, 200 to 202 and 76-2-15)
Pittsburgh; Mercy (76-1-225)
Pittsburgh; St. Margaret (76-1-266 and 267)

OTOLARYNGOLOGY
Bedford Springs (76-1-417)
Philadelphia; Temple (76-1-203 and 76-2-16)
Pittsburgh; Mercy (76-1-224 and 226-228)
Pittsburgh; Mercy (76-2-20)
Pittsburgh; Eye and Ear Hosp. (75-2-72)
Pittsburgh; Eye and Ear Hosp. (76-1-238 to 240 and 246)
Pittsburgh; Pitt (76-1-241)

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Hershey; M.S. Hershey (76-1-322)
Philadelphia; Albert Einstein Med. Cntr. (Northern) (76-1-101 to 102)
Philadelphia; Episcopal Hosp. (76-2-4 and 5; 11 and 12)
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Philadelphia; MCP (76-2-31)
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Sayre; Packer (76-1-273)

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Danville; Geisinger (76-1-48 and 55)
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Hershey; M.S. Hershey (76-1-323)
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Philadelphia; Children's Hosp. of Phila. (75-2-43)
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Pittsburgh; West Penn (75-2-8)

PHARMACOLOGY
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Philadelphia; EPPI (75-2-45)

PHYSICAL MEDICINE & REHABILITATION
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Harrisburg; Physical Medicine and Rehabilitation (75-2-97)
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Philadelphia; Temple (76-1-215)
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Pittsburgh; Mercy (76-1-224)

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Philadelphia; EPPI (76-1-114)
Philadelphia; Hahnemann (76-1-147)
Philadelphia; U. of Pa. (76-1-383)

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Pittsburgh; Pitt (76-1-247)
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UROLOGY
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Hershey; M.S. Hershey (76-1-320)

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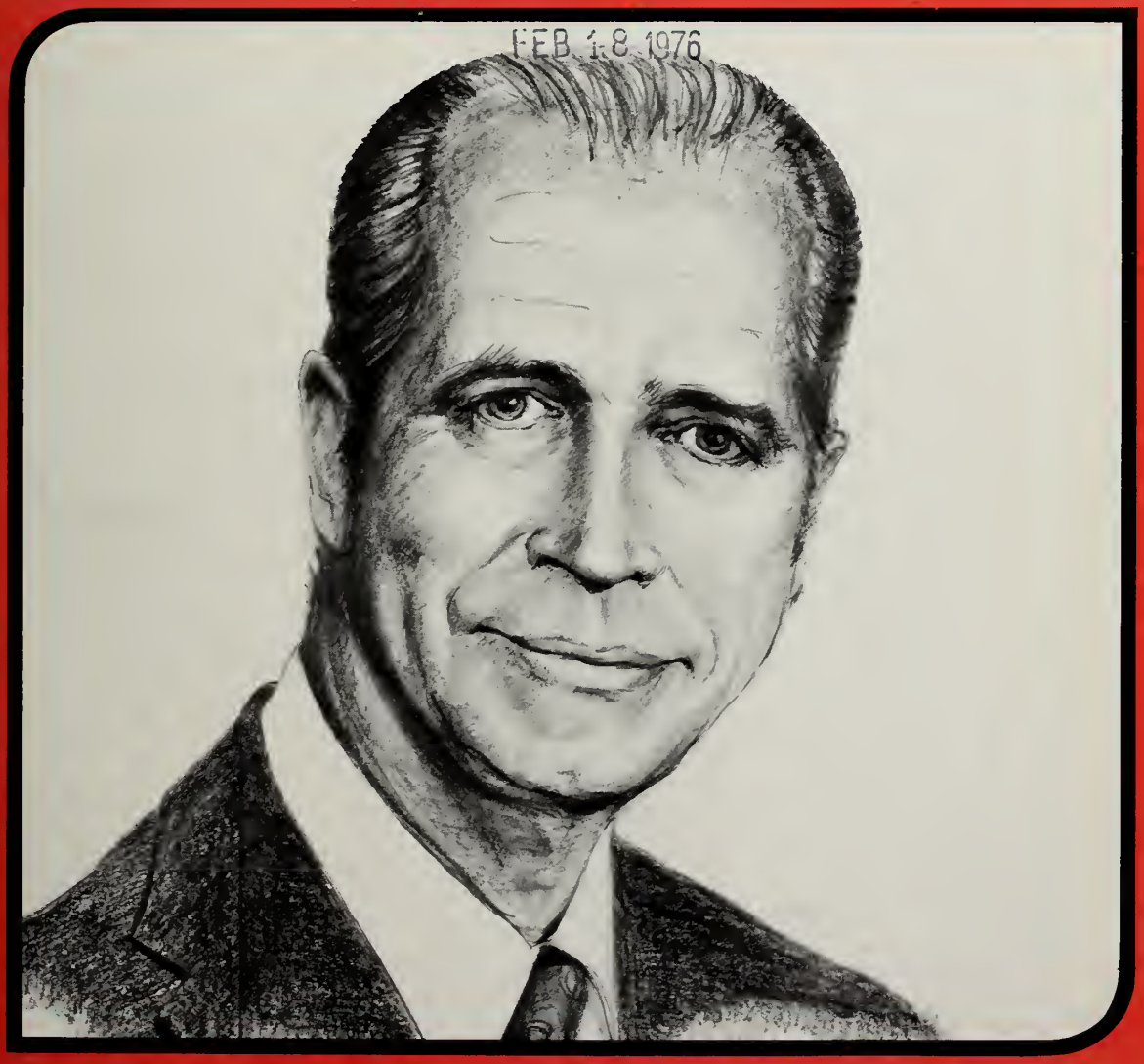

David S. Masland, M.D., 126th President
Pennsylvania Medical Society

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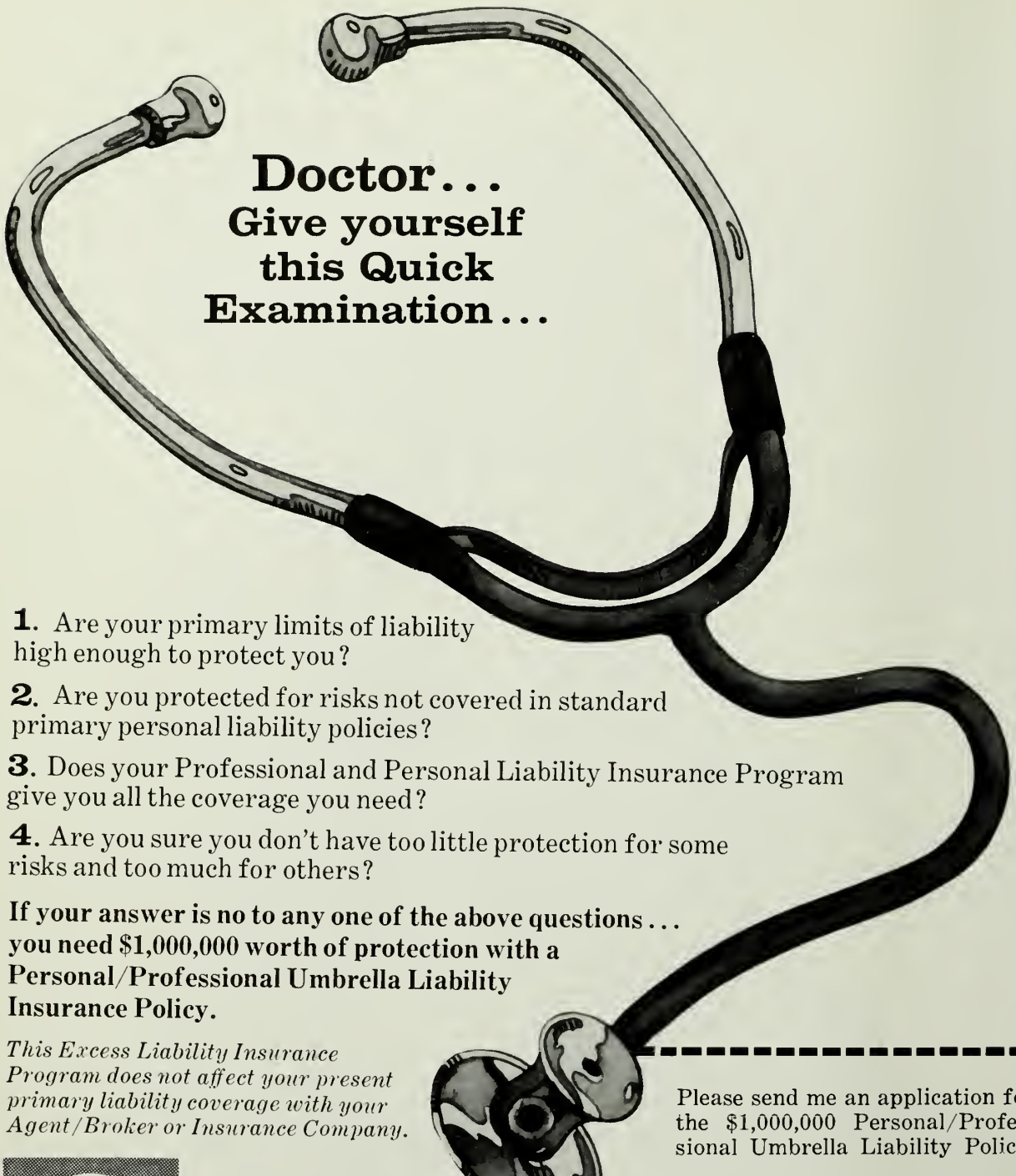

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SENATE PASSES MALPRACTICE BILL The State Senate by unanimous vote October 2 passed an amended H.B. 1367, the "Health Care Services Malpractice Act." As the bill now stands, major provisions are:

1. Arbitration panels will be new for each case. The so-called "virgin panels" will be composed of two health care providers, two attorneys, and three lay persons. If possible at least one provider is to be a specialist in the specialty involved.
2. Findings of the arbitration panels are admissible as evidence in a court if the case is appealed.
3. The administrator of the arbitration process is appointed by the governor, but will function outside the Insurance Department. He will promulgate rules and regulations to implement the bill.
4. The statute of limitations has reverted to two years after discovery. The bill provides, however, that any claim filed four years from occurrence can be paid only from the Catastrophe Loss Fund.
5. Physicians must purchase insurance with limits of $100,000 per occurrence, $300,000 aggregate. In any claim, a doctor's insurance company is liable for only $100,000 per occurrence. Any amount in excess of that limit and up to $1 million would be paid from the Catastrophe Loss Fund, which is supported by surcharges on physicians of $100 or 10 percent of insurance premiums, whichever is higher. The limit of liability of the fund is $1 million per occurrence and $3 million per annual aggregate.
6. A backup Joint Underwriting Association is provided to permit the insurance commissioner to provide insurance for health care providers who cannot conveniently obtain insurance in the commercial market.
7. The provision in the bill abolishing risk classification is deleted.
8. The bill contains unique features so that if the concepts fail--if the Catastrophe Loss Fund is depleted or the backup JUA fails--the whole problem returns to the Legislature for a new solution.
9. On informed consent the bill says the "general nature of the proposed procedure" must be disclosed, but the requirement that consent be "freely given" has been deleted.
10. Promises to cure must be in writing and signed to be valid.

See the Medigram of the August issue of PENNSYLVANIA MEDICINE for other highlights of the bill as passed by the House of Representatives July 21.

INSURANCE DEPARTMENT TO STUDY BLUE SHIELD Insurance Commissioner William J. Sheppard has announced that the department will undertake a study of Blue Shield claims and payments "to determine whether the giant health plan is paying for unnecessary medical and surgical procedures." The announcement was made October 1 at a public hearing on Blue Shield's request for a 27.7 percent ($35.3 million) rate increase which would affect about half the plan's subscribers. Commissioner Sheppard said he would seek a meeting with officers of the Pennsylvania Medical Society and the Pennsylvania Osteopathic Medical Association to seek cooperation in the study. Preliminary target date for release of the findings is April 1, 1976.

HEARINGS ON X-RAY BY RX ONLY The State Environmental Quality Board will hold public hearings late in October on proposed regulations which would require a prescription by a medical professional for all x-rays. Dr. Maurice K. Goddard, secretary of the Department of Environmental Resources, said hearing dates will be announced soon so that final approval of the regulations can come up for a vote at the November meeting of the Environmental Quality Board. The regulations would prohibit the kind of screening done by local tuberculosis societies, for example.

NURSING HOMES UNDER HEALTH DEPARTMENT Health Secretary Leonard Bachman, M.D., has announced that the Department of Health has assumed the responsibility formerly held by the Welfare Department for the supervision, approval, and licensing of nursing homes. Secretary Bachman said the move involves about 670 nursing homes, and requires the transfer of personnel, funds, and equipment to perform the function from the Welfare to the Health Department. Regulations governing the operation of nursing homes, originally proposed by the Department of Public Welfare, were made final by the Department of Health following the transfer which became effective September 1.

HOUSE OF DELEGATES IN SESSION The State Society's House of Delegates, meeting in Lancaster October 6-8, will elect a vice president, trustees for the Third and Ninth Districts, five delegates and five alternate delegates to the AMA, two members of the Committee to Nominate Delegates and Alternates to the AMA, the speaker and vice speaker of the House of Delegates, the Society secretary, two Judicial Council members, and district censors. Malpractice legislation, clinical laboratory regulations, proposed generic prescribing legislation, and the proposed comprehensive health care act will receive consideration from delegates.

PHILADELPHIANS PROTEST HSA DESIGNATION The Philadelphia County Medical Society, Philadelphia Council of the AFL-CIO, and Mayor Frank J. Rizzo have sent a joint letter to Vice President Nelson A. Rockefeller, chairman of President Ford's Domestic Council, protesting the designation of the five county Philadelphia area as a Health Service Area (HSA) under the National Health Planning and Resources Development Act (P.L. 93-641). County commissioners, county medical societies, and other groups from the counties of Bucks, Chester, Delaware, and Montgomery, have expressed similar dissatisfaction with the designation finalized September 2. The letter to the vice president calls for a review of the appropriateness of the HSA designation by the secretary of the Department of Health, Education, and Welfare and requests the vice president to arrange a conference with F. David Mathews, the new secretary.

EYE CARE PROGRAM APPROVED The Blue Shield Board of Directors has approved the marketing to groups of a program for eye examination and refraction by either ophthalmologists or optometrists, who will be paid on the basis of respective usual, customary, and reasonable charges. Included are allowances toward the cost of glasses and contact lenses when needed.

pennsylvania medicine

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Cover art by David H. Small, assistant executive vice president, Pennsylvania Medical Society

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PENNSYLVANIA MEDICINE, established in 1897, is published monthly as the official publication of the Pennsylvania Medical Society. All original papers and correspondence should be directed to the Managing Editor. Subscription requests and changes of address should be sent to PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043. A subscription is $5.00 per year. Single issues are 50 cents. Second class postage is paid at Lemoyne, Pennsylvania 17043.

Both often

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard ant convulsant medication; abrupt withdrawa may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mus cle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, though primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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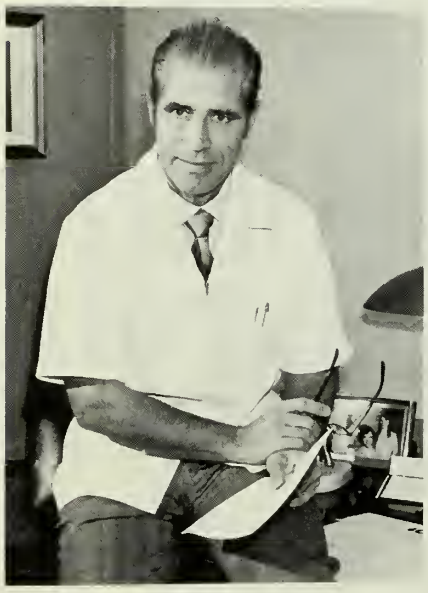
Dr. Masland assumes Society presidency

David S. Masland, M.D., of Carlisle, who becomes president of the Pennsylvania Medical Society on October 7 values action and tradition. His belief in action will serve to guide his year as president as it has served to guide his life. His involvement in organized medicine springs from this philosophy.



"I believe it is better 'to do' than 'to be.' When I first became involved in organized medicine I saw things in the socioeconomic world that deleteriously affected the practice of my profession. Organized medicine gave me a much needed outlet for my frustration at those impediments—a chance to effect changes for the total good."

This affirmation of organized medicine comes at a time when the problems confronting the medical profession multiply. Through his consistent involvement, Dr. Masland has lived his belief in organized medicine.

Dr. Masland's active involvement began at the county level where he has held most of the offices in the Cumberland County Medical Society, including secretary-treasurer and president. At the State Society level, he was a delegate to the House of Delegates for many years, and has served on numerous Society committees and councils. Among these are the Finance Committee, the Publication Committee, and the Council on Governmental Relations.

In 1963 he was elected as Trustee and Councilor of the Fifth Councilor District, holding that position for two terms. In 1968 he became vice chairman and then, in 1971, chairman of the Board of Trustees. He was elected as vice president in 1973, and has served the last year as president elect of the State Society. At 51, he is one of the youngest presidents to serve the Society.

The sense of tradition initially led Dr. Masland into his career choice. "My mother always wanted to be a physician, but the untimely death of her father meant she had to give up her education. My becoming a physician continued a tradition reaching back eight generations in my family."

A graduate of Princeton University, with an M.D. degree from the Thomas Jefferson University (1948), Philadelphia, Dr. Masland took his internship and residency at Cooper Hospital in Camden, New Jersey. After a two year interruption to serve in the United States Navy, he completed his residency in 1954, and was board certified by the American Board of Internal Medicine in 1956.

After a brief practice in New Jersey with his physician uncle, Dr. Masland returned, in 1955, to his hometown of Carlisle to set up a solo practice, which he has since expanded to include three partners. He is also on the staff of the Carlisle General Hospital where he is currently chief of medicine.

One of the sources of satisfac-

DR. MASLAND, left, with William J. Kelly, M.D., right, who becomes president elect at the 1975 Annual Session of the House of Delegates.

tion for Dr. Masland is the practice of his profession. Looking back, he says, "I can't imagine being anything else. The opportunity a physician has to help people is a unique privilege. One of the reasons I particularly chose internal medicine was my desire to have a high degree of patient contact."

Dr. Masland's family is another source of great satisfaction. He and his wife, Elizabeth, have a son, David, Jr., and two daughters, Janet and Barbara. Leisure time is devoted to outdoor interests. Dr. Masland particularly enjoys those activities which afford opportunity to observe nature—such as hiking.

In his address before the House of Delegates, Dr. Masland summarizes his combined belief in action and tradition. Looking ahead to the year of his presidency he says, "When physicians work together as a team and get involved, we remain free to practice as our training and experience tell us in this, the greatest and noblest of professions—medicine."

Blue Shield receives federal grant

Pennsylvania Blue Shield has received a $108,000 research grant from the Department of Health, Education, and Welfare's Bureau of Health Services Research. The grant will extend and expand Blue Shield's study of a flat rate per case reimbursement to physicians for in-hospital medical care.

The project's purposes are to determine the effects of the new reimbursement method on the overall cost of medical care and to evaluate the method's impact on the length of stay for in-hospital care.

The federal assistance will cover 75 percent of the cost of the last half of the study begun in 1974 and will expand the project's size from 5 hospitals and 52 physicians to 10 hospitals and 140 physicians.

Under the flat rate per case reimbursement being studied, physicians will receive just one payment based on the discharge diagnosis of the patient when he leaves the hospital. The project will test this payment method on 37 specific diagnoses.

Immunize in October

During the month of October, declared Immunization Action Month, the Pennsylvania Department of Health is increasing its efforts to see that all school children are protected against diseases such as polio, measles, diphtheria, tetanus, and pertussis.

In a recent press conference, Secretary of Health Leonard Bachman estimated that 36 percent of the school age children nationally and as many as a half million in the state have not been properly immunized. The health department is making an "all-out effort," according to Dr. Bachman, to protect school children from the childhood diseases. Parents are urged to consult their physicians to make sure their children are given adequate protection.

continuing education

This issue carries no education course listings. The September issue contained a supplement—a comprehensive list of education courses being offered in all parts of Pennsylvania. Consult that issue or write for a copy of the supplement to: Pennsylvania Medical Continuing Education Institute, 20 Erford Rd., Lemoyne, PA 17043.

Blue Shield schedules further assistants' courses

Pennsylvania Blue Shield is sponsoring special office assistants' meetings explaining claims submission procedures. The Society Board of Trustees urge physicians to send their assistants to these meetings. Below is a listing of the scheduled meetings in central Pennsylvania. For a list of meetings in eastern and western Pennsylvania see the August issue of PENNSYLVANIA MEDICINE.

October 8, 9:30 a.m., Polyclinic Hospital, Harrisburg

October 8, 10:00 a.m., Walck's Restaurant, Lehighton

October 8, 9:00 a.m., Sheraton Motor Inn, Williamsport

October 9, 9:30 a.m., Capitol Motel Restaurant, Harrisburg

October 15, 10:00 a.m., Nesbitt Memorial Hospital, Kingston

October 16, 9:30 a.m., Osteopathic Hospital, York

October 21, 9:30 a.m., Holiday Inn, Chambersburg

October 22, 9:30 a.m., Hanover Hospital, Hanover

October 23, 9:30 a.m., Waynesboro Hospital, Waynesboro

October 28, 9:30 a.m., Holiday Inn, Chambersburg

October 30, 9:30 a.m., Annie Warner Hospital, Gettysburg

November 14, 9:30 a.m., 2:00 p.m., Blue Shield Building-West, Camp Hill

Symposium on alcoholism

The department of psychiatry of the Medical College of Pennsylvania will present the Ninth Annual Symposium on the Psychodynamic Implications of Various Physiological Studies November 9 at 9:00 a.m. in the auditorium of the college.

"Psychodynamic Implications of the Various Studies in Alcoholism" is the symposium topic which will be discussed by experts from all over the country. Speakers include: Laurence H. Snow, M.D., professor of psychiatry at the Medical College of Pennsylvania; Henry L. Rosett, M.D., associate professor of psychiatry and career teacher in drug abuse and alcoholism (NIAAA-NIDA) at Boston University School of Medicine; Henry Krystal, M.D., professor of psychiatry at Michigan State University School of Medicine; Austin Silber, M.D., clinical associate professor of psychiatry at SUNY Downstate School of Medicine; and Morris E. Chafetz, M.D., director of the National Institute on Alcohol Abuse and Alcoholism.

The symposium is acceptable on an hour for hour basis in Category I credit towards the Physician's Recognition Award of the American Medical Association. Registration is advisable due to limited seating capacity. The registration fee is $25. For tickets or more information contact the Department of Psychiatry, The Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia, PA 19129; (215) 842-6923.

Society roster available

The Society 1975-76 Roster is now available to members. The contents of the Roster includes component county society officers, county society members with their addresses and specialty codes, and an alphabetical list of members showing county affiliation.

PMS members may obtain a complimentary copy by contacting Society Headquarters, 20 Erford Rd., Lemoyne, PA 17043. Additional copies are $15.

ABRAM M. HOSTETTER, M.D., right, vice chairman of the Commission of Education and Manpower, shown with LeRoy Erickson, director of educational activities, testified recently on behalf of the Society concerning proposed legislation to restructure and broaden the Bureau of Professional and Occupational Affairs, which contains the State Board of Medical Education and Licensure. Dr. Hostetter reminded the House Committee on Professional Licensure that proposed malpractice reform legislation provides that the State Board should receive funds to enforce the new Medical Practice Act strictly, and that the State Society supports this position.

Medical Arts '75 programs announced

The Pennsylvania Medical Society will sponsor Medical Arts '75, thirteen scientific and educational programs for continuing medical education. The programs will be held over a three day period, Wednesday, November 5, to Friday, November 7, at the Host Inn, Harrisburg.

Medical Arts '75 will offer medical programs in internal medicine, colon and rectal surgery, allergy, orthopaedics, physical medicine and rehabilitation, and plastic surgery. Programs concerning administrative medicine, Pennsylvania Blue Shield, medical assistants, and medical educators, which may be of interest to administrators, office aides and assistants, and educators, as well as physicians, are also included in the schedule.

Programs are sponsored by various organizations in the state. Among them are: the Pennsylvania Allergy Association; Pennsylvania Society of Internal Medicine; Pennsylvania Society of Colon and Rectal Surgery; Pennsylvania Society, American Association of Medical Assistants, Inc.; Pennsylvania Blue Shield; the Pennsylvania Academy of Physical Medicine and Rehabilitation; the Robert H. Ivy Society; and the Pennsylvania Orthopaedic Society. Many of the sessions will offer Category I credit toward the Physician's Recognition Award of the American Medical Association.

For more information about a particular program, contact the PMS Council on Education and Science, 20 Erford Road, Lemoyne, PA 17043.

Emergency seminar set

The New Jersey Chapter of the American College of Emergency Physicians and the Emergency Department Nurses Association will present their fifth annual seminar in "Advances in Emergency Medicine." The seminar will be held November 12 and 13 at the Hyatt House in Cherry Hill.

For more information about the seminar, contact Rudolf Schwaeble, M.D., president, New Jersey Chapter, American College of Emergency Physicians, P.O. Box 308, Wharton, NJ 07885.

State to control health devices

A new regulation made by the Pennsylvania Department of Health states that all state manufacturers, distributors, and retailers of health related devices must register with the department or face legal citation. The new regulation is the Health Department's accelerated plan to protect consumers from substandard health devices and products. Such health related devices include hearing aids, eyeglasses, pacemakers, bandages, artificial limbs, splints, and other surgical appliances.

Secretary of Health Dr. Leonard Bachman said that ". . . products which do not deliver what they promise will be taken off the market."

Academy of surgery supports colleague

The Philadelphia Academy of Surgery has issued a position statement regarding Dr. Candadai S. Rangarathnam, a pediatric surgeon who faces criminal charges in connection with a case in which a patient died after a diagnostic procedure. The statement, in part, follows:

"The members of the Council of the Academy have carefully reviewed the case in question and believe that the procedure was medically indicated and properly performed, and that Dr. Rangarathnam, is fully qualified. These findings were endorsed unanimously by the members at a special meeting on July 28, 1975. They understand the grief and anguish of the bereaved parents and sympathize with them. It must be appreciated, however, that diagnostic procedures essential to the practice of medicine are not without risk. Despite precautions, complications, and even rarely, death may occur. If necessary diagnostic and treatment modalities are to be withheld because of the fear of these complications, or because of the physician's fear of criminal charges, then patient care will suffer.

"The fellows of the Academy believe that the action taken against Dr. Rangarathnam is not justified and that it has a severe and deleterious effect on the proper practice of medicine. As a tangible evidence of their support, they have voted to make financial contributions to his defense and to publicly decry the action taken against him."

Surcharges investigated

Resolution 75-S-20, introduced at the Special Session of the Society House of Delegates held July 2 and 3 in Harrisburg, called on all Pennsylvania physicians to compute and add a surcharge on all bills. Although the resolution was rejected, the House agreed with the reference committee that individual physicians should use their own best judgment regarding this practice.

Subsequent research has indicated that at least with some insurance companies, particularly Pennsylvania Blue Shield, the surcharge could be a problem. Since the surcharge is not a "medical service," Blue Shield does not consider it eligible for payment.

in my opinion

Physicians barred from primary eye care?

Can you imagine a new health care plan for Pennsylvanians that would have thousands of people with potentially blinding glaucoma, keratitis, iritis, uveitis, conjunctivitis, corneal abrasion and similar conditions reporting to non-medical practitioners for disposition? Many more thousands would have less serious conditions, of course. But by actual plan, they would be seen *first* by someone without benefit of medical training and education.

That someone—an optometrist—would have the awesome responsibility of either "diagnosing" patients' problems, treating those patients, or referring them to a physician; hopefully, in time to prevent blindness or irreparable damage because of delayed treatment. *All* decisions at this primary level of entry into the eye health care system would be made by an optometrist. The patient with an eye problem would be referred to a physician *only* if the optometrist feels it is necessary.

Then, the referred patient would be instructed to see the physician at his *hospital,* not in his office. Physicians, who examine the eyes of their patients routinely, would provide eye care only on the secondary and tertiary levels. Ophthalmologists, in effect, would be shut out of their offices, despite the fact that 93 percent of the ophthalmologists' patient contacts are presently made there.

It hasn't happened yet, but it could under an astonishing proposal by organized optometry which asks the Department of Health to appoint optometrists as the primary eye care persons in the Commonwealth. The Pennsylvania Optometric Association says optometrists are well qualified for this responsibility and that, among other things, they can diagnose and treat eye diseases!

The truth is they simply cannot diagnose or treat eye diseases. A district court in Colorado agreed earlier this year when optometrists in that state also aspired to the primary delivery system for eye care, thus relegating physicians to a secondary and subservient position in the field of eye health. The court enjoined optometrists from detecting or diagnosing glaucoma. It found that glaucoma is a disease and can be diagnosed only by medical doctors, not optometrists. The court further found that detecting and diagnosing glaucoma are the same.

Contained in the Pennsylvania optometric proposal is the suggestion that optometrists can treat "minor ocular injuries and pathologies." This is a dangerous attempt to invade the practice of medicine. Certainly to the patient, there is no such thing as a minor eye disease or a minor injury. Furthermore, the claimed capability to *treat* such inherently medical conditions should come as a surprise to a generous legislature which endowed optometrists last year with the legal right to use drugs for *diagnostic* purposes only. The *treatment disclaimer* must have appeared in more than 1,000 optometric inspired letters to legislators.

In staking its claim to primary eye care, optometry employs a bit of shallow reasoning. It admits that it takes twice as long to produce a certified ophthalmologist (which has something to do with quality of care provided), at approximately three times the cost. It then contends that optometrists, on a national basis, provide three times as much "eye care" as all ophthalmologists and all other physicians combined!

Those asked to make this new award to optometry must understand that primary eye care is essentially medical in nature. Ambulatory patient care services in ophthalmologists' offices alone are about 95 percent medical, as distinguished from surgical services. These services consist of in-office medical diagnosis and treatment. Only physicians and osteopaths are presently trained and, indeed, are presently authorized legally to diagnose and treat disease.

When a patient has an ocular complaint or reduced vision, the primary responsibility is to determine the *cause* of the problem. This is a medical evaluation, which *includes* refraction. If the patient needs only corrective lenses, an optometrist can measure the refractive error and provide glasses. He thus provides a most useful service, within his normal purview.

All physicians are dedicated to the prevention, diagnosis, and treatment of disease. This constitutes the maintenance of good health, a basic medical responsibility fulfilled best by those trained in medicine. Can there be any justification for compromising the high quality eye care now available to Pennsylvanians by assigning the primary level of care to non-physicians who are unable to deal with medical considerations?

It is not for optometry to tell physicians how to practice medicine!

Louis E. Silcox, M.D., President
Pennsylvania Academy of
Ophthalmology and Otolaryngology
Philadelphia

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Now you can save up to 50 percent on your office medical supplies. In the Co-op warehouse are over 250 different kinds of products, available for immediate delivery, and additional items which are being added as requested. Orders are shipped via the United Parcel Service within 24 hours of receipt. Here's a chance to cut overhead and make your dollars work for you. SATISFACTION GUARANTEED.

The Pennsylvania Medical Cooperative is another PMS Membership benefit. Only members of the Pennsylvania Medical Society may buy from the Co-op. What does it cost to join the Co-op? It doesn't cost—it pays. If you were to buy one case of each of the items offered by the Co-op, in one year your savings over currently suggested retail prices would be $501. That $501 would more than cover your lifetime membership in the Co-op ($200), your PMS dues ($150), and your county dues. Use the application below.

(Please make checks payable to the Pennsylvania Medical Cooperative.)

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I am a member of the Pennsylvania Medical Society. Please enroll me as a member of the Pennsylvania Medical Cooperative. Enclosed you will find a check in the amount of $200 to cover the membership requirement. It is my understanding that this is a one-time subscription entitling me to a vote in the affairs of the Cooperative plus giving me the right to purchase all medical supplies offered by the Cooperative.

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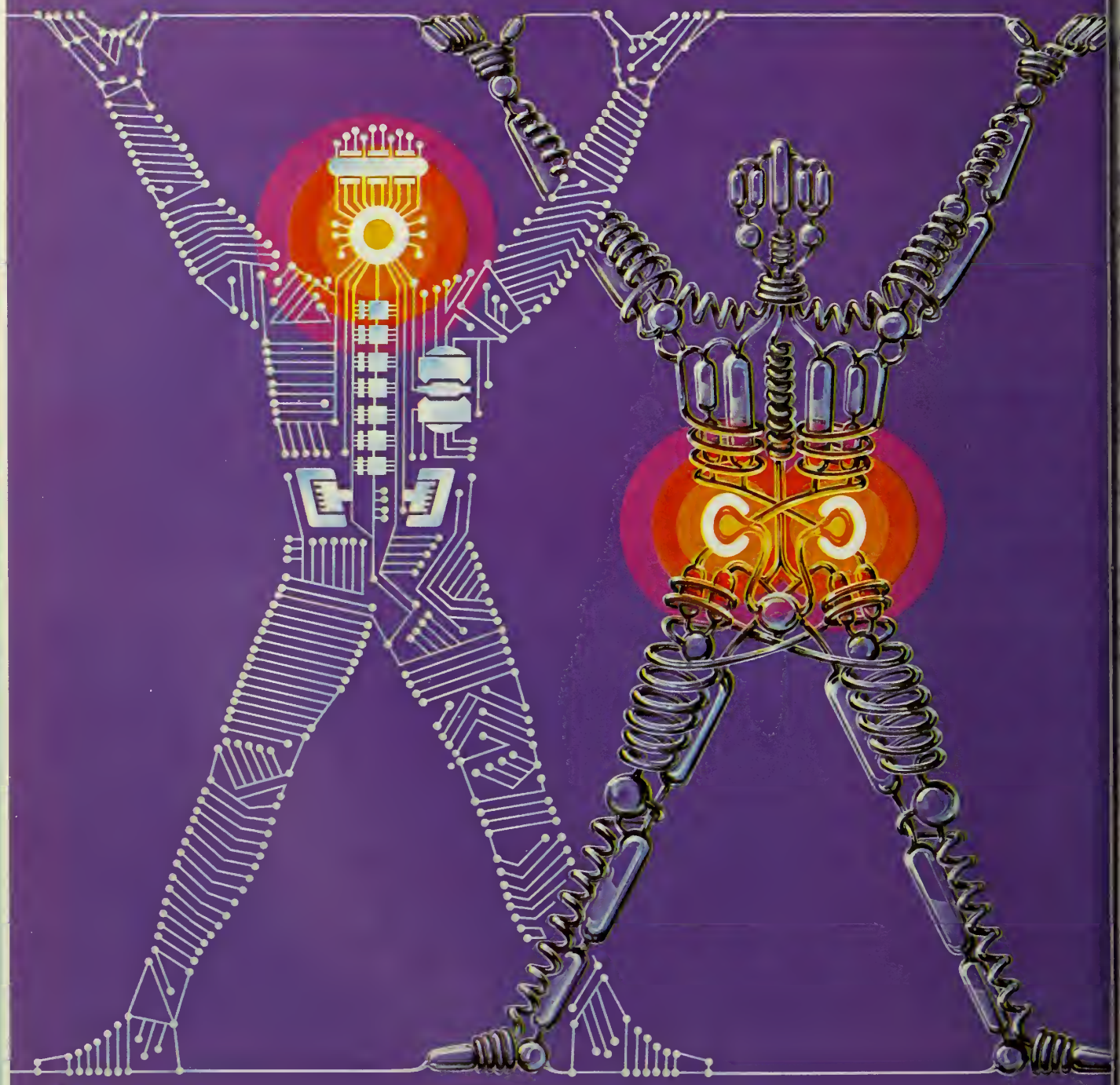
nonreserpine

Combipres®

.1 and .2

Each tablet contains:
Catapres®, brand of clonidine hydrochloride,
0.1 or 0.2 mg and chlorthalidone, 15 mg

The only major new combination antihypertensive in a decade



Please see brief summary of the prescribing information including precautions, warnings, adverse reactions.

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Combipres® 1 and 2

Each tablet contains:
Catapres,® brand of clonidine hydrochloride, 0.1 or 0.2 mg and chlorthalidone, 15 mg

Works better than either component in equivalent doses*

Works in mild to severe hypertension

Works conveniently for patients who need more than one drug*

Works for less than the cost of separate Rxs*

Works and works and works—convenience and economy promote long-term patient compliance

Combipres is not indicated for initial therapy of hypertension. It is indicated for hypertensive patients who need more than one drug for adequate lowering of blood pressure and who have proved to be responsive to its components given separately in dosages equivalent to those in the combination.

Warning: This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

Indication: The drug is indicated in the treatment of hypertension (see box warning).

Contraindications: Patients with known hypersensitivity to chlorthalidone and patients with severe renal or hepatic diseases.

Warnings: Tolerance may develop in some instances necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxicity findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefit outweighs the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Combipres in children.

Precautions: When discontinuing Combipres, reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of Combipres therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect of the clonidine hydrochloride component. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other antihypertensive agent, Combipres should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Combipres should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmological findings have been recorded with Catapres, in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Patients predisposed toward or affected by diabetes should be tested periodically while receiving Combipres, because of the hyperglycemic effect of chlorthalidone.

Because of the possibility of progression of renal failure, periodic determination of the BUN is indicated. If, in the physician's opinion, a rising BUN is significant, the drug should be stopped.

The chlorthalidone component of Combipres may lead to sodium and/or potassium depletion. Muscular weakness, muscle cramps, anorexia, nausea, vomiting, constipation, lethargy or mental confusion may occur. Severe dietary salt restriction is not recommended in patients receiving Combipres.

Periodic determinations of the serum potassium level will aid the physician in the detection of hypokalemia. Extra care should be given to detection of hypokalemia in patients receiving adrenal corticosteroids, ACTH or digitalis. Hypochloremic alkalosis often precedes other evidence of severe potassium deficiency. Frequently, therefore, more sensitive indicators than the potassium serum level are the serum bicarbonate and chloride concentrations. Also indicative of potassium depletion can be electrocardiographic alterations such as changes in conduction time, reduction in amplitude of the T wave; ST segment depression; prominent U wave. These abnormalities may appear with potassium depletion before the serum level of potassium decreases. To lessen the possibility of potassium deficiency, the diet, in addition to meat and vegetables, should include potassium-rich foods such as citrus fruits and bananas. If significant potassium depletion should occur during therapy, oral potassium supplements in the form of potassium chloride (3 to 4.5 gm/day), fruit juice and bananas should be given.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy.

Clonidine hydrochloride: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one case of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash; impotence, urinary retention; increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Chlorthalidone: Symptoms such as nausea, gastric irritation, anorexia, constipation and cramping, weakness, dizziness, transient myopia and restlessness are occasionally observed. Headache and impotence or dysuria may occur rarely. Orthostatic hypotension has been reported and may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics. Skin rashes, urticaria and purpura have been reported in a few instances.

A decreased glucose tolerance evidenced by hyperglycemia and glycosuria may develop inconsistently. This condition, usually reversible on discontinuation of therapy, responds to control with antidiabetic treatment. Diabetics and those predisposed should be checked regularly.

As with other diuretic agents hypokalemia may occur (see Precautions). Hyperuricemia may be observed on occasion and acute attacks of gout have been precipitated. In cases where prolonged and significant elevation of blood uric acid concentration is considered potentially deleterious, concomitant use of a uricosuric agent is effective in reversing hyperuricemia without loss of diuretic and/or antihypertensive activity.

Idiosyncratic drug reactions such as aplastic anemia, thrombocytopenia, leukopenia, agranulocytosis, and necrotizing angiitis have occurred, but are rare.

The remote possibility of pancreatitis should be considered when epigastric pain or unexplained gastrointestinal symptoms develop after prolonged administration.

Other adverse reactions which have been reported with this general class of compounds include: jaundice, xanthopsia, paresthesia and photosensitization.

Overdosage: *Catapres (clonidine hydrochloride):* Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals abolishes all effects of Catapres overdosage.

Chlorthalidone: Symptoms of overdosage include nausea, weakness, dizziness, and disturbances of electrolyte balance. There is no specific antidote, but gastric lavage is recommended, followed by supportive treatment. Where necessary, this may include intravenous dextrose and saline with potassium administered with caution.

How Supplied: Combipres® 0.1 (Each tablet contains clonidine hydrochloride 0.1 mg + chlorthalidone 15 mg). It is available as pink, oval, single-scored compressed tablets in bottles of 100.

Combipres® 0.2 (Each tablet contains clonidine hydrochloride 0.2 mg + chlorthalidone 15 mg). It is available as blue, oval, single-scored compressed tablets in bottles of 100.

For complete details, please see full prescribing information.

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Elmsford, New York 10523

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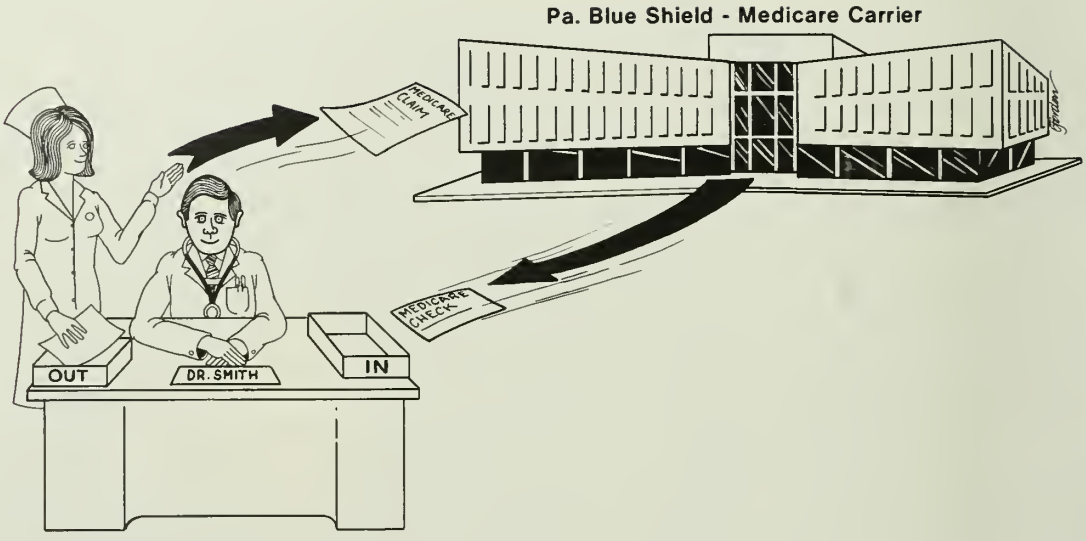

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practice management

Selecting and obtaining the best office - part three

EIF C. BECK, LL.B.

ASILIOS J. KALOGREDIS, J.D.

ala Cynwyd

'. . . Purchasing or constructing a practice building is a very complex and dangerous matter which requires careful planning. Too often the economic analysis occurs only by hindsight, when the problems come home to roost . . . use of advisors before *commiting to ownership is far preferable to consulting with them after the fact.'*

Last month we discussed the many important considerations in leasing office space—the simplest and most common way a physician or medical group takes its facility. Many doctors, however, choose instead to purchase their office buildings or even to buy land and have buildings constructed for their ownership. In these situations, the economics are far more significant regarding both risks and opportunities, and they certainly deserve extensive attention. This last of our series of articles on office selection deals with purchasing or building one's own office facility.

General desirability

If *flexibility* is the key word in obtaining the best office arrangement, then a physician's purchasing or building his own facility is in most cases an undesirable approach. One's ownership tends to restrict his receptivity to moving elsewhere when the practice patterns change; for example, if the space becomes overcrowded by the addition of physicians and staff, or if new office space becomes available at a still better location.

There are nevertheless two justifiable reasons for the doctor's becoming owner of his office space. First, it will be a good investment from an ownership standpoint. Second, satisfactory office space is simply not available for rent. If either or both of these factors truly exist, the time, effort, and economic risk of ownership may be acceptable—but only if the doctor has been honest with himself in considering them.

Economic analysis

Any venture into office building ownership should be taken only after careful economic projections are made and critically evaluated. Unfortunately, however, doctors

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.

all too often have only a vague understanding of those numbers, and even their attorneys and/or accountants make only superficial analyses. To rely upon persons who would have any economic stake in the project, including a developer, contractor, or real estate broker, to make those projections carries a risk that is often discovered later.

Building ownership should logically be broken down to its two economic parts: cost of using the space and return on the investment. Thus, even a solo physician constructing this single-practice building can and should evaluate the project as though he were *separately* an owner and a tenant. He can then determine what "fair rent" he would have to pay (to himself) to make his ownership an acceptable investment, comparing the figure to space he could possibly lease from others. If that rental figure is high, the doctor or his estate may later find the building to be a poor investment.

Appendix A (below) presents a "Sample Economic Analysis of Building Ownership." It attempts to present for a prospective owner's review many of the factors which go into determining his "fair rent" and his possible economic return. It contains, however, a great many items which must be questioned extremely critically. They include:

(a) In estimating construction costs of a new building, have the related items been included at realistic figures? For example, engineering and site improvement costs may be considerable; the interest on a construction loan will be at a still higher rate than the final mortgage loan; legal and accounting services will be necessary; and so on.

(b) Are there likely to be considerable "cost overruns" as the developer later increases the originally estimated figures? Many builders tend to understate the cost estimates and then increase them, as overruns, as the project unfolds. This is known as "conditioning" and can be built into the original projections by inquiring of the builder's last three or four customers what percentage overruns occurred and applying that percentage to the estimated figure.

(c) Have such operating expenses as janitorial and snow removal been recognized? Have utilities been fairly estimated? Are all those expenses projected with perhaps a 10 percent to 20 percent "cushion" for contingencies and inflation?

(d) Is a mortgage loan really available at the assumed interest rate, over the assumed loan term and most importantly, in the assumed amount and percentage of total value? Has it or can it be committed before undertaking expensive steps?

(e) Is a fair cash return to the owner(s) built into the rental calculation? Even if less or no rent will be charged because the owner and user are the same, a 10 percent apparent return would seem minimal for the risk and work involved.

(f) Has the "required annual rental" been calculated on the recognition that some of the square footage cannot be leased? The entrance lobby, elevator space, hallways, and utility rooms may reduce the rentable space considerably, thus increasing the per square foot rental rate.

(g) Have the projections recognized that a larger build-

(Continued on page 32.)

PROLOID® (thyroglobulin)
Caution: Federal law prohibits dispensing without prescription.
Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.
Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.
The ratio of T_4 and T_3 in Proloid (thyroglobulin) is approximately 2.5 to 1.
Proloid (thyroglobulin) is stable when stored at usual room temperature.
Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.
In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.
Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.
Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.
Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.
Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.
Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.
Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.
Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, $T_3{}^{131}I$ resin sponge uptake, $T_3{}^{131}I$ red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.
Instructions for Use. The following conversion table lists the approximate equivalents of other thyroid preparations to Proloid (thyroglobulin) when changing medication from desiccated thyroid, T_4 (sodium levothyroxine), T_3 (sodium liothyronine), or T_4/T_3 (liotrix).

CONVERSION TABLE

Dose of Proloid (thyroglobulin)	Dose of Desiccated Thyroid	Dose of T_4 (sodium levothyroxine)	Dose of T_3 (sodium liothyronine)	Dose of liotrix (T_4/T_3)
1 grain	1 grain	0.1 mg	25 mcg	#1 (60 mcg/15 mcg)
2 grains	2 grains	0.2 mg	50 mcg	#2 (120 mcg/30 mcg)
3 grains	3 grains	0.3 mg	75 mcg	#3 (180 mcg/45 mcg)
4 grains	4 grains	0.4 mg	100 mcg	
5 grains	5 grains	0.5 mg	125 mcg	

In changing from Thyroid USP to Proloid (thyroglobulin), substitute the equivalent dose of Proloid (thyroglobulin). Each patient may still require fine adjustment of dosage because the equivalents are only estimates.
Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.
(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)
Supplied. ¼ grain tablets in bottles of 100 (N0047-0250-51) and 1000 (N0047-0250-60); ½ grain tablets in bottles of 100 (N0047-0251-51) and 1000 (N0047-0251-60); scored 1 grain tablets in bottles of 100 (N0047-0252-51) and 1000 (N0047-0252-60); 1½ grain tablets in bottles of 100 (N0047-0253-51) and 1000 (N0047-0253-60); scored 2 grain tablets in bottles of 100 (N0047-0257-51); 3 grain tablets in bottles of 100 (N0047-0254-51) and 1000 (N0047-0254-60); scored 5 grain tablets in bottles of 100 (N0047-0255-51) and 1000 (N0047-0255-60). Full information is available on request. P-GP-51 4/c

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Division, Warner-Lambert Company
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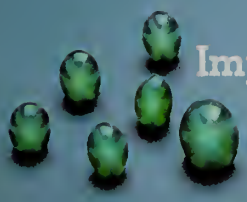

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from the rough, uncut stone
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all the qualities of the "natural" with the added improvements of man...

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Devoid of any glandular debris.

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Standardized chemically, biologically, and (at intervals) clinically, for consistent metabolic activity from batch to batch.

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Potency undiminished for up to 4 years under proper storage conditions.

It all adds up to natural thyroid with the added improvements of man.

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- **less sodium**—36% less sodium than the next leading antacid.

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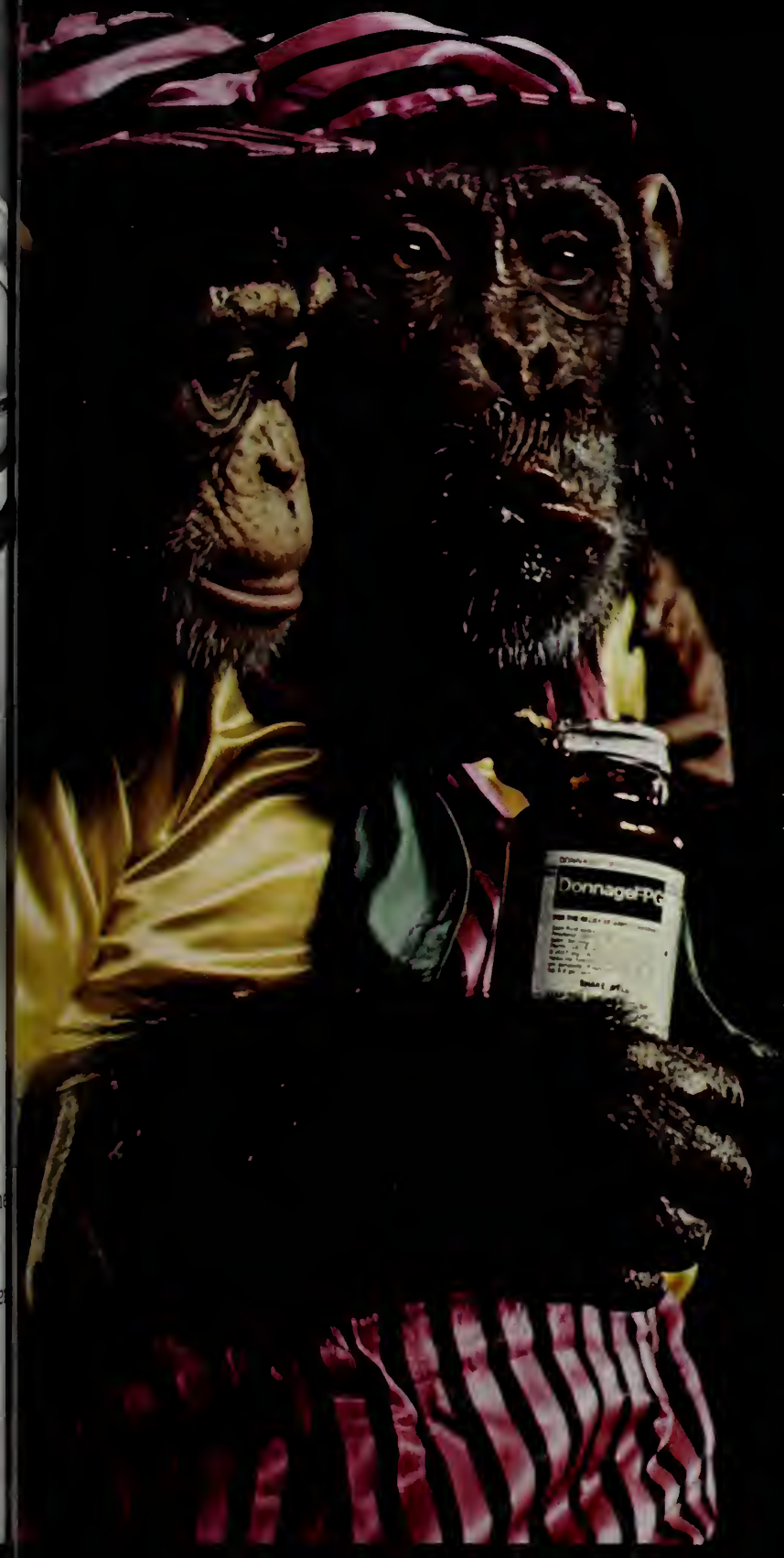

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Donnagel with paregoric equivalent

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Kaolin	6.0 g.
Pectin	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Powdered opium, USP (equivalent to paregoric 6 ml.) (warning: may be habit forming)	24.0 mg.
Sodium benzoate (preservative)	60.0 mg.
Alcohol, 5%	

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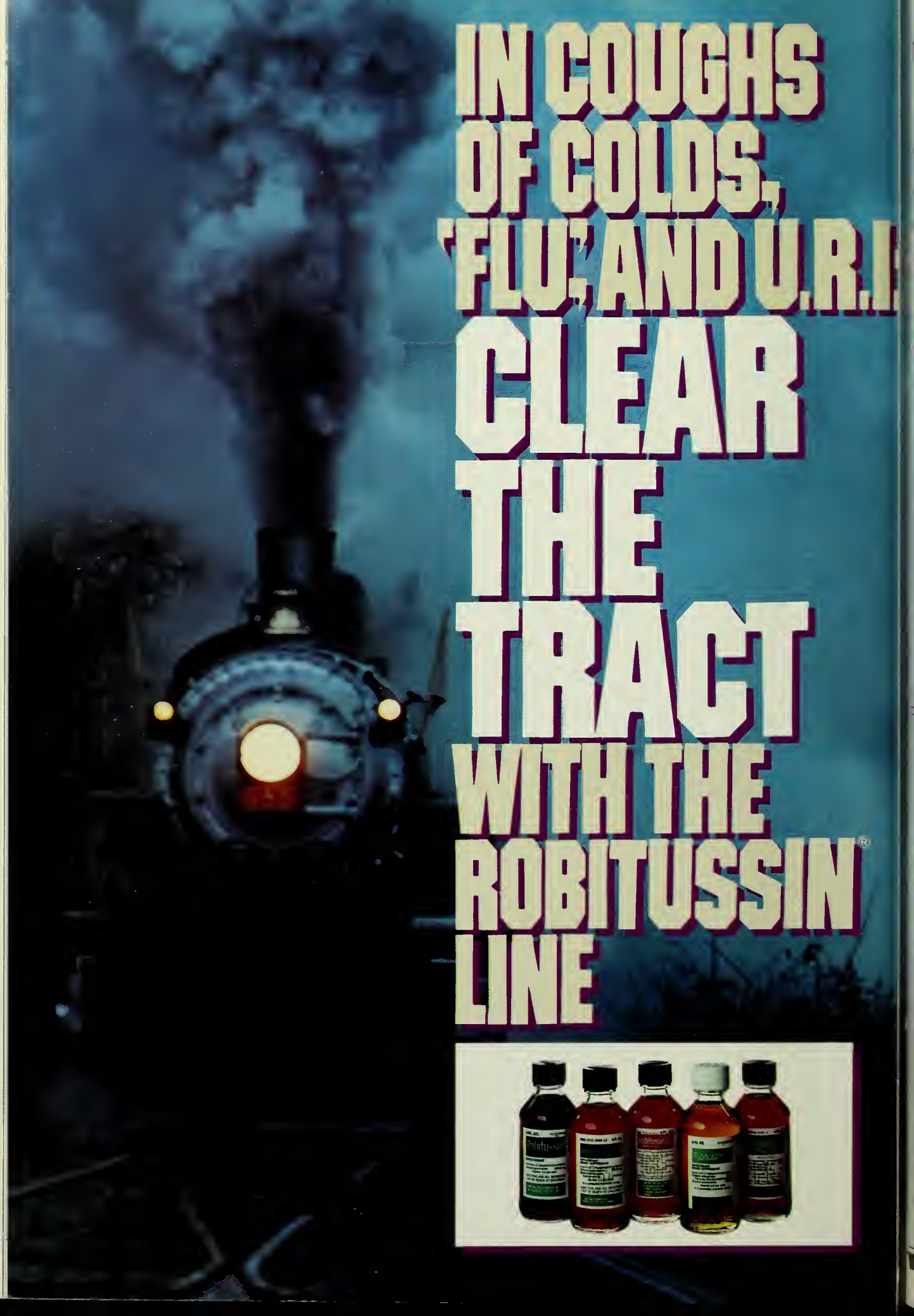
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LINE

THE 5 RELIABLE ROBITUSSINS can really help clear the respiratory tract. All contain guaifenesin,* the expectorant that works systemically to help stimulate the output of lower respiratory tract fluid. This enhanced flow of less viscid secretions promotes ciliary action and makes thick, inspissated mucus less viscid and easier to raise.

*formerly named Glyceryl Guaiacolate

For productive and unproductive coughs

ROBITUSSIN®

Each 5 ml teaspoonful contains:

Guaifenesin, NF.	100 mg
Alcohol, 3.5%	

For severe coughs

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Each 5 ml teaspoonful contains:

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Codeine Phosphate, USP.	10.0 mg
(warning: may be habit forming)	
Alcohol, 3.5%	

Non narcotic for 6-8-hr. cough control

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Each 5 ml teaspoonful contains:

Guaifenesin, NF.	100 mg
Dextromethorphan Hydrobromide, NF.	15 mg
Alcohol, 1.4%	

Decongests nasal passages and sinus openings as it helps relieve coughs

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Pseudoephedrine** Hydrochloride, NF.	30 mg
Alcohol, 1.4%	

**Formerly contained Phenylephrine Hydrochloride 10 mg

Decongestant action helps control cough and clear stuffy nose and sinuses. Non narcotic.

ROBITUSSIN-CF®

Each 5 ml teaspoonful contains:

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Phenylpropanolamine Hydrochloride, NF.	12.5 mg
Dextromethorphan Hydrobromide, NF.	10 mg
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A. H. Robins Company, Richmond, Va 23220 A·H·ROBINS

For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines. In keeping with this tradition, the company recently commissioned a well-known illustrator to render full-color drawings of several classic locomotives...accurate to the minutest detail. The first of the series is now available. To order your print suitable for framing, write "Robitussin Clear-Tract Engine #1" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.

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is a famous fighter, too.

Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS**: Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING**: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS**: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS**: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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MDs in the news

Henry Hood, M.D., executive director of Geisinger Medical Center, Danville, was recently elected to the board of trustees of Bucknell University. Dr. Hood is president of the Montour County Medical Society, chairman of the Accreditation Commission of the American Group Practice Association, and a past president of the Mid-Atlantic Neurosurgical Society.

Hahnemann Medical College and Hospital recently appointed **Anna Freud, LL.D., Sc. D., M.D. Hon.**, as visiting professor of child psychiatry. Dr. Freud is director of the Hampstead Child-Therapy Course and Clinic, London, and daughter of Sigmund Freud.

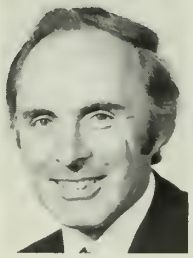
Bernard J. Alpers, M.D., emeritus professor of neurology at Jefferson Medical College, received the first Jeannes Annual Mandel Neurological Lectureship, which was given at Jeannes Hospital recently. Dr. Alpers spoke on "Clinical and Pathological Corelations in Metastatic Brain Carcinoma." **Martin M. Mandel, M.D.**, established the lectureship in honor of his father, Samuel.

The Pennsylvania State University College of Medicine at The Milton S. Hershey Medical Center has made six new appointments to the medical staff. They are: **Earl A. Palmer, M.D.**, pediatric ophthalmologist; **Dennis W. Schneck, M.D.**, assistant professor of medicine and pharmacology; **Barbara H. Roberts, M.D.**, assistant professor of medicine in the division of cardiology; **Timothy S. Harrison, M.D.**, professor of surgery and physiology; **Joan M. Sulewski, M.D.**, assistant professor of obstetrics and gynecology; and **Kenneth W. Teich, M.D.**, assistant professor of obstetrics and gynecology and codirector of the Pennsylvania State University affiliated obstetrics and gynecology residency program at Harrisburg Hospital.

Andrew J. Kapcar, M.D., was recently named associate pathologist at Harrisburg Hospital.

Helen L. Smits, M.D., recently became associate administrator for patient services at the Hospital of the University of Pennsylvania. She is assistant professor of medicine and health care systems in the university's school of medicine. Dr. Smits recently received a national appointment to serve on the Advisory Panel on National Health Insurance of the Health Subcommittee of the Committee on Ways and Means.

DR. SMITS



DR. GILL

Donald J. Gill, M.D., was named chairman of the department of psychiatry at Mercy Catholic Medical Center recently. He will administer and coordinate services of both the Fitzgerald Mercy and Misericordia Divisions.

Leonard F. Bush, M.D., spent September in the Dominican Republic on a voluntary tour of duty with CARE-MEDICO. Dr. Bush is a clinical professor of surgery at The Milton S. Hershey Medical Center. During his tour, Dr. Bush instructed resident surgeons and technicians in the latest techniques in orthopedic surgery.

Jeannette District Memorial Hospital honored **Charles P. Snyder, M.D.**, medical director, at his recent retirement dinner. He had served as medical director since 1967. Dr. Snyder is a past president of the Westmoreland County Medical Society.

Donald M. Blatchley, M.D., was appointed clinical associate professor in the division of dermatology at the West Virginia University School of Medicine recently. Dr. Blatchley is past president of the Westmoreland County Medical Society.

Joseph C. Maroon, M.D., recently became president elect of the Pittsburgh Neuroscience Society. Dr. Maroon is associate professor and chief of neurological surgery at Presbyterian-University Hospital, University of Pittsburgh.

Harold J. Isard, M.D., was elected recently as a member of the board of trustees of the Albert Einstein Medical Center. He has been chairman of the Northern Division's radiology division since 1964 and is clinical professor of radiology at the Temple University School of Medicine.

P. Kirk Pandelidis, M.D., chairman of York Hospital's department of psychiatry, was recently named a fellow of the American Psychiatric Association. Dr. Pandelidis is secretary treasurer of the Pennsylvania Psychiatric Society and director of the York County Mental Health Center.

Roland A. Loeb, M.D., recently became a fellow of the International Academy of Cytology. Dr. Loeb is president of the Lancaster City and County Medical Society.

John L. Atkins, M.D., York, was recently named to the board of trustees of York College. Dr. Atkins is assistant professor of medicine at the University of Maryland School of Medicine.

A new library at Geisinger Medical Center's Ear, Nose, and Throat Center was named for **Francis W. Davison, M.D.**, during recent dedication ceremonies. Dr. Davison is presently senior consultant at Geisinger. He is a past president of the American Broncho-Esophagological Association, the American Laryngological, Rhinological and Otological Society, and the American Larynogological Association. The new library is designed to hold 2,500 medical books and periodicals.

Harold Winn, M.D., was named associate director of professional education and of affiliate educational programs at the Philadelphia Psychiatric Center recently. He will direct two new affiliated programs for psychiatric training of medical students and expand the continuing education programs. Dr. Winn is clinical associate professor of both psychiatry and obstetrics and gynecology at Temple University Medical Center, and director of the extension division of the Philadelphia Psychoanalytic Institute and Society.

DR. WINN

DR. MARSH

Herbert M. Bergman, M.D., was recently appointed medical director of the Willowcrest-Bamberger health care facility, Philadelphia.

York Hospital recently held recognition ceremonies to honor five retired members of the staff for their dedicated service to the community. Honored were: **Charles E. Eisenhower, M.D., Charles L. Fackler, M.D., Bruce A. Grove, M.D., Ray W. Kehm, M.D.,** and **Milton H. Cohen, M.D.** Dr. Cohen was president of the York County Medical Society in 1934.

The Medical College of Pennsylvania recently appointed Julian B. Marsh, M.D., as professor and chairman in the department of physiology and biochemistry. Dr. Marsh has received such honors as the Bell Award, a Guggenheim Fellowship in Biochemistry, an invitation as a visiting scientist to the Mario Negri Institute in Milan, Italy, and an invitation to speak at the Biochemical Society Symposium in London.

Albert Fornace, M.D., Fort Washington, was honored recently by Suburban General Hospital for twenty-five years of service to the hospital and pioneering in the field of cardiopulmonary care. Dr. Fornace directs the hospital's intensive cardiac care unit.

Frank R. Episcopo, M.D., recently became chief of the surgical service at the Veterans Administration Hospital, Erie. He has been acting chief for the past year.

Geisinger Medical Center, Danville, recently appointed two associates on the staff. **Demetrio A. Aguila, Jr., M.D.,** has joined the division of rehabilitation medicine and **Richard S. Hinkle, D.O.,** has been appointed to the department of gynecology and obstetrics in the division of surgical services.

DR. AGUILA

DR. HINKLE

E. Joel Carpenter, IV, M.D., was recently named medical director of the Good Shepherd Home and Rehabilitation Hospital, Allentown.

SYMPOSIUM

MEDICAL LAW - MEDICAL ETHICS

HOW ARE WE ALL INVOLVED: THE PHYSICIAN, THE MEDICAL ASSISTANT, AND THE PATIENT

Saturday afternoon, November 8, 1975 and Sunday morning, November 9, 1975

PENNSYLVANIA SOCIETY AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS

Holiday Inn, Bedford, Pa. (US 220 @ Exit 11, Pa. Turnpike)

Sponsored by

SATURDAY, NOVEMBER 8, 1975

Registration	12:30-1:15
Program	1:30-5:30
Legal relationship of patient and physician	
Medical Ethics	
Professional Liability	
The Medical Assistant Liability	
Dinner	6:30

SUNDAY, NOVEMBER 9, 1975

Skit by AAMA members on office situations that might lead to malpractice suits. 9:30

Discussion of possible solutions to above.

REGISTRATION (includes Saturday & Sunday)

Free to Members	
Non-Members	$2.50
DINNER (Members and Non-Members)	$6.50

Please complete the registration form and mail it with your check payable to PENNSYLVANIA SOCIETY, AAMA, by November 3, 1975, to

MRS. DORIS EDMUNDSON, CMA, 2124 CALVIN ST., McKEESPORT, PA. 15132

REGISTRATION:

MEMBER ____

NON-MEMBER $____

DINNER $____

TOTAL ENCLOSED $____

NAME _____

ADDRESS _____

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EMPLOYER _____

cardiovascular brief

A Reporting System on Patients Evaluated For Coronary Artery Disease

Report of the Ad Hoc Committee for Grading of Coronary Artery Disease

Council on Cardiovascular Surgery

American Heart Association

This booklet, authored by nine nationally recognized cardiovascular specialists, offers a system for accumulating information about patients evaluated for coronary artery disease.

The system not only provides for evaluation of the influence of surgical and medical methods of management on the natural history of this disease but also will facilitate identification of both clinical and anatomic factors of prognostic importance in these patients.

There are four parts to the system: 1) the *Clinical and Arteriographic Report,* on which data relating to the patient is entered initially at the time of the first coronary arteriogram and which can be used each time a subsequent report of the status of the patient is made; 2) the *Surgical Report,* which is completed at the time of any cardiac operation; 3) the *Autopsy Report*; and 4) the *Booklet of Explanation and Instructions* for these three report forms.

A set of computer-compatible entry cards for storage and retrieval of information also is included in this report.

This Coronary Artery Disease Reporting System, developed at the request of the Council on Cardiovascular Surgery of the American Heart Association, should be of special interest to internists, cardiologists, surgeons, medical staff of hospitals, medical libraries and surgical nurses.

Copies of this report are available at $2.00 each from your local Chapter of the American Heart Association or write: American Heart Association, Pennsylvania Affiliate, P.O. Box 2435, Harrisburg, Pennsylvania 17105.

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Baylor College of Medicine

Dr. John Lindenbaum
Columbia University College of Physicians and Surgeons

Dr. David Potyk
Kaiser Permanente Hospital, Los Angeles

Dr. Melvin Rotner
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MS-GP-51

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editorials

Is education answer to cultism?

While physicians are enmeshed in a serious "battle" to maintain their professional integrity in the face of increasing governmental encroachment through financial policies and regulatory agencies, the cult of chiropractic has made considerable progress in the last decade toward achieving a recognized position in the medical care community. Not only have chiropractic degrees been acknowledged by the United States Office of Education but fees for certain chiropractic services are now available under medicare and medicaid.

Many writers have gone to great pains to show that chiropractic theory is the antithesis of science and reason. Studies on educational background and training have revealed that it is of poor quality with relaxed admission requirements to colleges, inadequately grounded instructors, coupled with no hospital training. Since chiropractic theory readily identifies all human disorders with malfunctions of the nervous system, treatable by spinal manipulation, little or no emphasis is placed upon differential diagnosis.

Organized medicine has opposed chiropractic since its inception as a form of quackery and, as such, potentially injurious to the health and safety of the public. This position is reinforced by a number of cases reported in the literature. Because of its concerned action, the American Medical Association has been accused of professional bias and the chiropractors' response has been vehement. Organized medicine's opposition threatens the livelihood of the chiropractor but the reverse is not so.

And yet, unbelievable as it may seem, an estimated three to five million people consult chiropractors annually. After examining the advertisements which appear in almost every local newspaper, one wonders why a reasonable individual would give these fantastic cure claims more than a passing glance. One reason is that chiropractors have become associated in the public mind with back specialists, possibly by the nature of their public notices which almost always include a graphic of the spine. For those patients who suffer from incurable diseases, perhaps the chiropractor represents a last hope, a sort of faith healer. He probably does make them "feel better" but claims of cure are gross misrepresentations and, by his methods, are far beyond the realm of medical possibility.

The Pennsylvania Medical Society has made numerous legislative advances in controlling the practice of chiropractic in the state. (PENNSYLVANIA MEDICINE, November 1974) Perhaps a campaign of public re-education to the dangers of non-medical spinal manipulation is in order.

David A. Smith, M.D.
Medical Editor

correspondence

Welfare official takes issue

To the Editor:

The June 1975 issue of PENNSYLVANIA MEDICINE printed an article entitled: "Whither PSRO-1975," written by Matthew Marshall, Jr., M.D. I should like to comment on several statements in his article.

Dr. Marshall states: ". . . there is no clear indication that State Government is willing to voluntarily delegate to PSROs the type of review actively intended by Congress." Contrary to Dr. Marshall's opinion, the Department of Public Welfare has publicly supported PSRO activities on many occasions and has been working closely with the Pennsylvania Medical Care Foundation to foster PSRO development in Pennsylvania. The Department took the initiative on October 1, 1974 to convert from a retrospective utilization review process conducted by the State to a concurrent utilization review process conducted by each hospital, in order to effect a smooth transition to PSRO implementation. The Department recognizes the need for physicians to review and monitor medical care and has endorsed the Certified Hospital Admission Monitoring Program (CHAMP) developed by the Pennsylvania Medical Care Foundation. This system is currently used by 65 hospitals in the State.

To further assist physician groups to gain experience on the local level with the utilization review process, the Department of Public Welfare has actively encouraged Medical Societies and PSRO groups to establish peer review committees to adjudicate appeals of hospital cases denied under the Department's former retrospective review system.

Physicians were advised that the decisions of the peer review committees would be accepted by the Department. The Pennsylvania Osteopathic Medical Association instituted such a peer review process in 1973 for the Osteopathic Hospitals. To date, 525 cases have been settled by this process and there is little or no backlog of cases under appeal at those participating hospitals. The physicians in PSRO Areas V and IX established similar peer review committees which are currently adjudicating hospital appeals. Unfortunately, PSRO groups in other parts of the State were not able to elicit the physician cooperation necessary to establish additional peer review committees, although the Department has encouraged these activities on numerous occasions. However, the Department does receive assistance from individual practitioners across the State, notably in the Philadelphia area, who conduct prehearing conferences for the Department. We are extremely grateful to the cooperating review committees and to the independent physicians statewide who are providing essential medical support to the Department.

Dr. Marshall cited the PAID Prescription Program as an example of the Department of Public Welfare's noncooperation, since PAID inadvertently established a statewide pharmacy peer review system in 12 geographic areas inconsistent with the PSRO boundaries. This disregard of the PSRO boundaries was not intentional but was due to PAID's unfamiliarity with PSROs and their geographic designations. On March 30, 1975, representatives of PAID presented their pharmacy peer review concept to the PMS Council on Medical Service. At that time, PAID became aware of the discrepancies between their boundaries and the PSRO Areas, and at my request, has since readjusted the geographic organization of their pharmacy peer review system to coincide with the PSRO Areas.

Despite the opinions stated in Dr. Marshall's article, the Department of Public Welfare has been and will continue to work cooperatively with the Pennsylvania Medical Care Foundation, local review committees and physicians to strengthen the peer review mechanisms for the Medical Assistance Program.

Roger A. Cutt, Ph.D.
Commissioner for Medical Programs
Pennsylvania Department of Public Welfare

Foundation clarifies

To the editor:

Dr. Cutt's July 24, 1975 letter to the Managing Editor of PENNSYLVANIA MEDICINE requires some clarification to avoid some misleading implications. At the time of the PMS Officers' Conference in April of this year, there was no formal commitment on the part of the Department of Public Welfare to accept the decisions of PSROs as to which hospitals were qualified to conduct their own review of medicaid admissions. It was only *subsequent* to my address to the Officers' Conference and a policy statement issued by HEW, that DPW *tentatively* agreed to recognize that PSROs have the legislative authority to determine the capability of a hospital to perform its own review. Although DPW has not yet formally signed a Memorandum of Understanding with a PSRO at this time, there has been substantial progress in recent weeks in delineating the respective responsibilities of DPW and the PSROs.

DPW's present contract with PAID Prescriptions, Inc. is an example of the Department's commitment to allow a nonprofessional organization to conduct "professional" review without any prior consultation with PMS, the Foundation, or any other physician group. This is of concern to the Foundation and the PSROs for the following reasons which existed at the time of Doctor Cutt's July 24 letter:

(1) The authority (or lack of authority) of DPW and PAID Prescriptions to conduct a peer review program which appears to be in conflict with the intent of the PSRO Legislation.
(2) The development and implementation of a peer review program without prior consultation with either the Pennsylvania Medical Society or the Pennsylvania Medical Care Foundation.
(3) Lack of action on the part of PAID Prescriptions to provide either the Foundation or PSROs with a responsible role in the program to provide peer review services. The program's review regions still do not conform to PSRO Areas.
(4) Lack of appropriate safeguards for patient confidentiality.

During late August and early September, the Foundation has made some progress with PAID to rectify the objections to the approach followed by PAID and DPW. For example, PAID agreed on September 7 to realign its review regions with PSRO areas.

I am hopeful that I can report to the PMS House of Delegates additional evidence of DPW's commitment to contract with physician organizations to perform professional review services and to recognize the authority of local practicing physicians, through their PSROs, to determine if hospital medical staffs are capable of performing appropriate review functions.

Matthew Marshall, Jr., M.D., President
Pennsylvania Medical Care Foundation

Opinion & Dialogue

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner, Food and Drug Administration

The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

Dr. James H. Sammons
Executive Vice President of the American Medical Association

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

ain purpose of drug information r the patient is to get his cooperaon in following a drug regimen.

reparation and distribution of atient drug information

We would hope to amass inforation from physicians, medical ocieties, the pharmaceutical indusy and centers of medical learning. ne ultimate responsibility for uniorm labeling must, however, rest ith the Food and Drug Administraon. There is nothing wrong with is agency saying, "this informaon is generally agreed upon and erefore it should be used," as long s our process for getting the inforation is sound.

Distribution of the information a problem. In great measure it ould depend on the medication in uestion. For example, in the case an injectable long-acting progesrone, we would think it mandatory issue two separate leaflets—a ort one for the patient to read bere getting the first shot and a long ne to take home in order to make a ecision about continuing therapy. this case, the information might e put directly on the package and ot removable at all. But for a mediation like an antihistamine this formation might be issued sepately, thus giving the physician the tion of distribution. This could eserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

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nly the doctor can remove that fear 20 or 30 minutes of conversation.

I'm not suggesting that we thhold any information from the atient because, first of all, it would totally dishonest and secondly, it ould defeat the very purpose of the sert. I do think that a patient on the rth control pill should know about e incidence of phlebothrombosis.

If you're going to tell a patient e incidence of serious adverse retions, then you have to tell him at a concerned medical decision as made to use a particular mediation in his situation after careful nsideration of the incidence of mplications or side effects.

notionally unstable patients pose special problem

There are patients who, because of severe emotional problems, uld not handle the information ntained in a patient package inrt. Yet if we are going to have a ckage insert at all, we just can't ve two inserts. I think we might nply have to tell the families of ese patients to remove the insert m the package.

gal implications of the patient ckage insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

Selecting and obtaining the best office — part three

(Continued from page 16.)

ing to be rented to others as well as to the owner(s) may be without tenants some of the time? Might even an owner-tenant cease to rent under some circumstances? If occupancy is at all a consideration, the assumed number of square feet rented should be reduced by 10 percent, 20 percent or more for economic feasibility purposes.

The example on Appendix A shows a fairly healthy outlook, with a caveat. That concern is whether a rental of nearly $9 per square foot is competitive in the community. If so, the doctor or doctors involved might consider the project to be an opportunity to average a 10 percent cash return subject to disproportionately heavy taxation (though much lower in early years and higher in later years) with a growing equity in the property. Assuming the land and building is likely to hold its value, or even appreciate, the investment would be a good one.

Single practice building

Building or purchasing an office building to house a single medical practice is an extremely risky undertaking. The smaller the practice, and hence the building, the greater the risk becomes. Hence, a solo physician might enter such a venture only with the realization that he might obtain little or no return on his investment.

A small medical building has a uniquely single purpose nature, that single purpose sometimes being required under the area's zoning laws. The resale market for such a building may thus be limited to other physicians practicing in the community, requiring similar office features and lacking satisfactory space of their own—almost no one! The alternative of selling the office for general commerical use, if zoning rules permit, may also be disappointing since commercial buildings normally are less expensive to build and hence less valuable upon resale.

If such an office is nevertheless to be constructed or purchased, proximity to a busy hospital would improve its economic outlook. New physicians joining that staff will likely seek space as close to the hospital as possible, thus increasing the possible resale market. The risk of a large rental building or campus developing on or adjacent to the hospital would, of course, be a negative factor, but even then the chances of attracting a buyer would usually be fairly good. Placing the single-practice building in a location far removed from other doctors would, on the other hand, obviously increase the described risks.

Since the single-specialty building must sooner or later be sold, whether due to the doctor's death, retirement or changed practice, the economic aspects of its ownership cannot be ignored. The office may be necessary or highly desirable as the best available facility, but in such a case it

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APPENDIX A

Sample Economic Analysis of Building Ownership
(On assumed figures—for example only)

A.	**Estimate of Total Costs**	
1.	Land	$50,000
2.	Construction cost (estimated 5,000 sq. ft. at $40 per sq. ft. assumed to include engineering costs, site improvements, construction loan interest, settlement costs, legal fees, insurance, etc.)	200,000
		$250,000
B.	**Possible Financing**	
1.	Cash to purchase land	$50,000
2.	Amount borrowed to have 80 percent financed	200,000
		$250,000
3.	TOTAL DOCTORS' INVESTMENT	$50,000
C.	**Estimated Operating Expenses**	
1.	Real Estate Taxes	$3,000
2.	Utilities	7,000
3.	Maintenance (including janitorial, snow removal, repairs and upkeep, etc.)	4,000
4.	Insurance (liability, fire)	1,000
5.	Legal, adminstrative, accounting	1,000
6.	TOTAL ESTIMATED OPERATING EXPENSES	$16,000
D.	**Financing Costs**	
1.	Mortgage principal (average over 20 yrs.)	$10,000
2.	Interest (average over 20 yrs. at 9%)	9,000
3.	ANNUAL DEBT SERVICE COSTS (nearly $1,600 per month)	$19,000

E.	**Rental Required to Produce 10% Return on Investment**	
1.	Annual cash outflow (sum of C and D above)	$35,000
2.	Plus 10% cash return on investment (10% of $50,000)	5,000
3.	REQUIRED ANNUAL RENTAL	$40,000
4.	Required rental per usable square foot (4,500 sq. ft.)	$8.89
F.	**Average Federal Tax Situation**	
1.	Proposed Annual rental income	$40,000
2.	Average annual interest	-9,000
3.	Average annual depreciation (over estimated 20 yrs. on composite basis, on assumed $175,000 building)	-8,800
4.	Estimated operating expenses	-16,000
5.	Average taxable income	$6,200
6.	AVERAGE ANNUAL FEDERAL TAX (50%)	$3,100
G.	**Average After-Tax Return to Doctors**	
1.	Proposed 10% return (item E -2)	$5,000
2.	Less average federal tax	-3,100
3.	AVERAGE NET AFTER-TAX CASH RETURN TO DOCTORS	$1,900
4.	Plus average reduction in loan principal (item D -1)	10,000
5.	AVERAGE ANNUAL AFTER-TAX RETURN AND INCREASE IN EQUITY	$11,900

$8.89 per sq. ft.*

should be recognized for those important factors despite its economics.

Multipractice building

A physician or a group of physicians might instead purchase or build a facility housing a number of practices. This may be more desirable economically since it creates a building with greater "drawing power" and hence hopefully greater rental prospects and resale value. Whether this will be true or not will obviously depend on many factors which must be evaluated critically in advance. There are a few particularly important matters.

Proximity to a hospital is of even greater importance to the economics of a larger medical complex. Furthermore, the possibility of the hospital itself building a medical office building on its own grounds must be considered. If such a facility will be still more convenient for its staff members, a private building's competitive disadvantage will become significant over the years.

One very appealing approach to developing a successful building venture is actual use of the hospital grounds. A group of physicians might join together to lease the raw land from the hospital and build the facility with their invested moneys. This should be favorable to the hospital in tying those doctors more closely to its fortunes while it receives rental income for use of its land. The doctors, on the other hand, would have the opportunity for convenient practice and for investment solely in the building, which, unlike the land, can be depreciated.

Experiences tend to show that a medical office building will lose much of its rental and resale value if it ceases to be occupied solely by health care professionals. Dentists, podiatrists, opticians, and other non-physician services may not be adverse, but opening the facility to others will create a risk of its declining appeal to physicians. Thus, realistic and honest evaluation of the medical "market" becomes vital before the venture is begun, including a recognition that some doctors' informal "yes" answer are not equivalent to signed rental commitments.

The sample economic analysis is at least as important to the larger medical complex as to the single-practice building. No doctor should be willing to commit himself to join into such a venture until *every* item on the projection has been evaluated and confirmed as being reliable. Furthermore, one must assume initial operating deficits until the building has a substantial number of tenants actually paying rent. The projection should also be realistic in assuming an ongoing vacancy factor of anywhere from 10 percent to 30 percent, for continuing full tenancy is an ideal difficult to fulfill even if there are initial leases for all the space.

A joint venture among a group of physicians leasing some of the office space for their own practices is quite common. Such a venture requires, however, much coordination and meeting time among the coventurers, which a busy physician should consider before joining up.

One member of the group will have to take an active leadership role in all the planning, evaluation, negotiation and communication. This will cause a very substantial interference to his practice and/or family time. If the group does not already have one such doctor, a prospective member should fear two things: (1) the group may flounder without good leadership, and (2) the new doctor may himself be stuck with the burden. Although a larger venture should have competent outside advisors, and an ongoing consultant or manager, who should not be the builder, developer or other interested party, such help will not relieve at least one of the physician members from responsibility and heavy time loss.

The joint venture can have the legal form of a partnership or a corporation, the decision being one primarily of income tax planning. More often than not, the proper choice will be a partnership so that the early years' paper losses can be passed through and deducted on the partner-doctors' personal income tax returns. The losses will appear because of heavy interest and depreciation allocations in the first few years, a limited form of "tax sheltering."

While the medical building venture may have considerable investment appeal, there are drawbacks to be evaluated. Perhaps most important, the venture may obligate the doctor's practice to a specific office location for an extended period of time. The owner group will typically be the backbone for rental purposes, locking themselves into five or ten years or longer to protect their common investment. This may not be the best thing for their practices, especially if they have continued growth potential and the building provides no chance to acquire more space.

A second concern is that joint building ventures may be extremely illiquid. A doctor may not be able to cash out his investment until or unless he dies, if even then. On the opposite side of this concern, if the agreement calls for the group's repurchase of a member's interest under various circumstances (death, retirement or simply a desire to withdraw from the investment), a doctor should question what would happen if several members had to be bought out at or near the same time. These contrasting concerns simply indicate the need for expert legal advice, but even with such help the doctors themselves should be sure to raise and focus discussion on the subject.

Conclusion

We hope it is clear that purchasing or constructing a practice building is a very complex and dangerous matter which requires careful planning. Too often the economic analysis occurs only by hindsight, when the problems come home to roost. While no one can assure a practice that his leadership will avoid the ownership pitfalls, use of advisors *before* committing to ownership is far preferable to consulting with them after the fact.

This three part series has dealt with the many considerations in providing one's practice with the best office possible under the circumstances. Flexibility, location, and office requirements are all important matters to reflect upon. Then a decision must be made as to whether leasing or owning the space would be most appropriate. Once that decision has been made, the considerations in negotiating a lease or building an office structure must be dealt with.

We hope this series has given our readers some food for thought when dealing with such matters.

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Because iodine content rather than biological assay is used to measure the standard of many desiccated thyroid products, biologic activity can vary from batch to batch. Even when biologic assay is employed, biologic activity can only be approximated.

1 It is recognized that T_4 and T_3 content in desiccated thyroid and thyroglobulin varies from animal to animal, by animal species, geography, and animal diet.

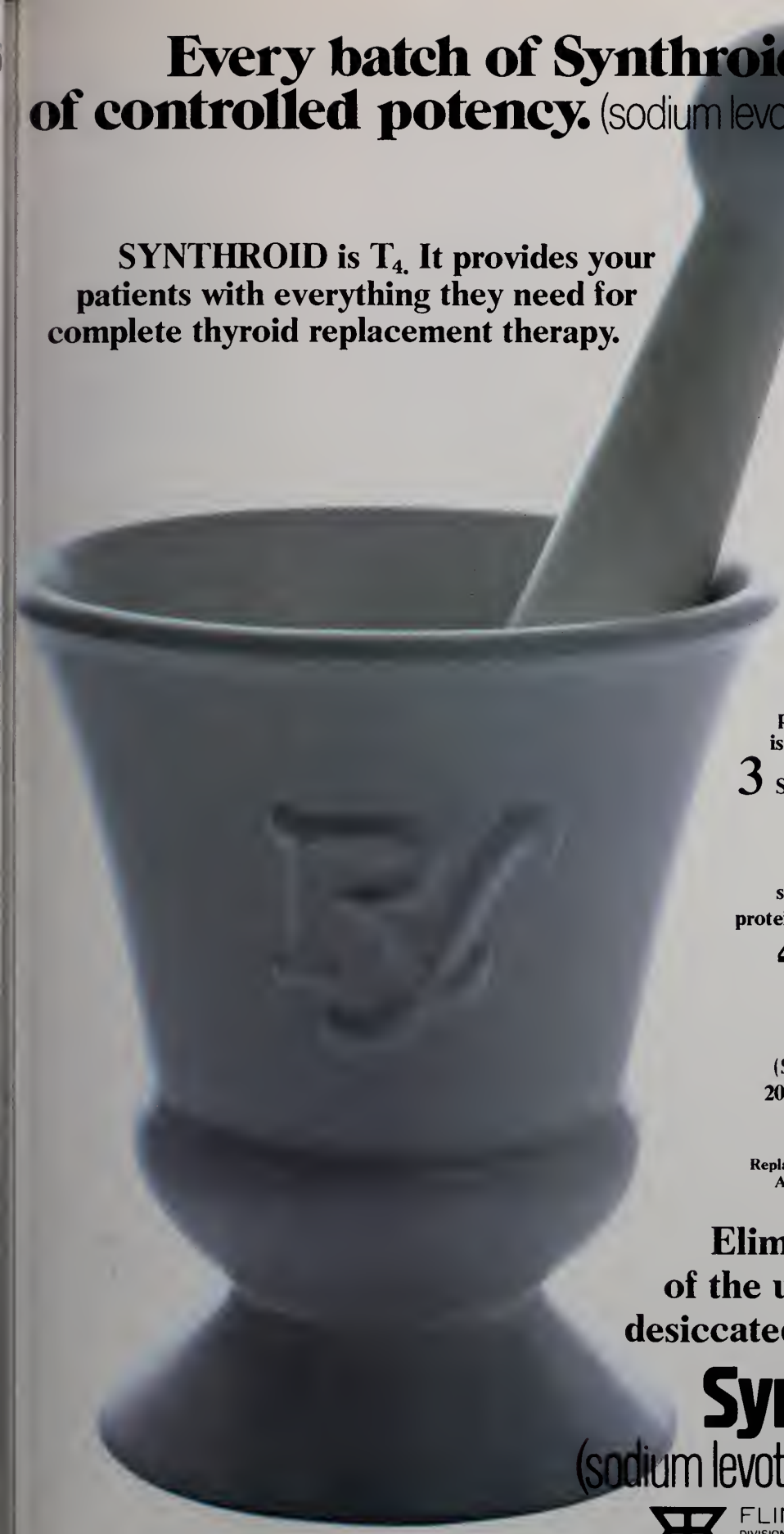
2 Of therapeutic concern: In addition to varying amounts of T_4, desiccated thyroid may contain varying amounts of T_3, a potent compound with rapid onset and fleeting action that can produce metabolic surges.

3 Even when kept under proper storage conditions, desiccated thyroid deteriorates more rapidly than the synthetic hormone.

4 The "usual maintenance dose" for the widely prescribed desiccated thyroid is "from 1 grain to 3 grains per day, but it may vary, in individual patients from 1/2 grain to 10 grains."[1] The "usual maintenance dose" of the most widely prescribed thyroglobulin (which is also a desiccated thyroid product) is "0.5 to 3.0 grains daily."[2]

1. Armour Thyroid (Tablets). 1975 Physicians' Desk Reference. p. 561.
2. Proloid® (thyroglobulin). 1975 Physicians' Desk Reference. p. 1575.

Every batch of Synthroid® T_4 is of controlled potency. (sodium levothyroxine, U.S.P.) FLINT



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1 Sodium levothyroxine is *not derived* from any animal gland source. It is a synthetic and, since sodium levothyroxine is the only active ingredient, its weight is the sole determinate of potency.

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4 A recent study of 44 patients with hypothyroidism indicates that 89 percent of the patients were maintained with doses of L-thyroxine (SYNTHROID) between 100 mcg. and 200 mcg. (0.1 mg. and 0.2 mg.) per day.[3]

3. Stock, J.M., Surks, M.I., and Oppenheimer, J.H.: Replacement dosage of L-thyroxine in hypothyroidism. A re-evaluation. New Engl. J. Med. *290*:529-33, 1974.

Eliminates many of the uncertainties of desiccated thyroid therapy.

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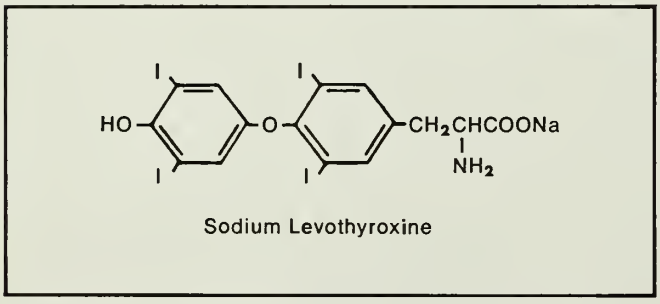
Synthroid Tablets—for oral administration
Synthroid for Injection—for parenteral administration

Description

SYNTHROID (sodium levothyroxine) **Tablets** and SYNTHROID **Injection** contain synthetic crystalline sodium levothyroxine (L-thyroxine). L-thyroxine is the principal hormone secreted by the normal thyroid gland.



Sodium Levothyroxine

Actions

SYNTHROID (sodium levothyroxine) **Tablets,** taken orally, provide hormone that is readily absorbed from the gastrointestinal tract. SYNTHROID **Injection** is effective by any parenteral route. Following absorption, the synthetic L-thyroxine provided by SYNTHROID products cannot be distinguished from L-thyroxine that is endogenously secreted. Each is bound to the same serum proteins and each exhibits a six to seven day circulating half-life in the euthyroid individual.

Both SYNTHROID products will provide L-thyroxine as a substrate for physiologic deiodination to L-triiodothyronine. Therefore, patients taking SYNTHROID products will demonstrate normal blood levels of L-triiodothyronine even when the thyroid gland has been surgically removed or destroyed by radioiodine. Administration of levothyroxine alone will result in complete physiologic thyroid replacement.

Indications

SYNTHROID (sodium levothyroxine) products serve as specific replacement therapy for reduced or absent thyroid function of any etiology. SYNTHROID **Injection** can be used intravenously whenever a rapid onset of effect is critical, and either intravenously or intramuscularly in hypothyroid patients whenever the oral route is precluded for long periods of time.

Contraindications

There are no absolute contraindications to SYNTHROID (sodium levothyroxine) therapy. Relative contraindications include acute myocardial infarction, uncorrected adrenal insufficiency and thyrotoxicosis. (See WARNINGS)

Warnings

Patients with cardiovascular diseases warrant particularly close attention during the restoration of normal thyroid function by any thyroid drug. In such cases, low initial dosage increased slowly by small increments is indicated. Occasionally, the cardiovascular capacity of the patient is so compromised that the metabolic demands of the normal thyroid state cannot be met. Clinical judgment will then dictate either a less-than-complete restoration of thyroid status or reduction in thyroid dosage.

Endocrine disorders such as diabetes mellitus, adrenal insufficiency (Addison's disease), hypopituitarism and diabetes insipidus are characterized by signs and symptoms which may be diminished in severity or obscured by hypothyroidism. SYNTHROID (sodium levothyroxine) therapy for such patients may aggravate the intensity of previously obscured symptoms and require appropriate adjustment of therapeutic measures directed at these concomitant disorders.

Thyroid replacement may potentiate the effects of anticoagulants. Patients on anticoagulant therapy should have frequent prothrombin determinations when instituting thyroid replacement to gauge the need to reduce anticoagulant dosage.

Precautions

Overdosage with any thyroid drug may produce the signs and symptoms of thyrotoxicosis, but resistance to such factitious thyrotoxicosis is the general rule. With SYNTHROID (sodium levothyroxine) **Tablets,** the relatively slow onset of action minimizes the risk of overdose but close observation in the weeks following institution of a dosage regimen is advised. Treatment of thyroid hyperactivity induced by oral medication is confined to interruption of therapy for a week, followed by reinstitution of daily therapy at an appropriately reduced dosage.

Adverse reactions

Adverse reactions are due to overdose and are those of induced hyperthyroidism.

Dosage and administration

For most adults, a final dosage of 100 mcg (0.1 mg) to 200 mcg (0.2 mg) of SYNTHROID (sodium levothyroxine) **Tablets** daily will restore normal thyroid function and only occasionally will patients require larger doses. Failure to respond adequately to a daily oral intake of 400 mcg (0.4 mg) or more is rare and should prompt reconsideration of the diagnosis of hypothyroidism, special investigation of the patient in terms of malabsorption of L-thyroxine from the gastrointestinal tract or poor adherence to therapy.

The concomitant appearance of other diseases, especially cardiovascular diseases, usually dictates a replacement regimen with initial doses smaller than 100 mcg/day (0.1 mg).

In otherwise healthy adults with relatively recent onset of hypothyroidism, full replacement dose of 150 mcg (0.15 mg) or 200 mcg (0.2 mg) has been instituted immediately without untoward effect and with good therapeutic response. General experience, however, favors a more cautious approach in view of the possible presence of subclinical disorders of the cardiovascular system or endocrinopathies.

The age and general physical condition of the patient as well as the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage. In the elderly patient with long standing disease, evidence of myxedematous infiltration and symptomatic, functional or electrocardiographic evidence of cardiovascular dysfunction, the starting dose may be as little as 25 mcg (0.025 mg) per day. Further incremental increases of 25 mcg (0.025 mg) per day may be instituted at three to four week intervals depending on patient response. Conversely, otherwise healthy adults may be started at higher daily dosage and raised to the full replacement dosage in two to three weeks. Clearly it is the physician's judgment of the severity of the disease and close observation of patient response which determines the rate of dosage titration.

Laboratory tests to monitor thyroid replacement therapy are of limited value. Although measurement of normal blood levels of thyroxine in patients on replacement regimens frequently coincides with the clinical impression of normal thyroid status, higher than normal levels on oral replacement of levothyroxine occasionally occurs and should not be considered evidence of overdosage per se.

In all cases, clinical impression of the well-being of the patient takes precedence over laboratory determination in determining the appropriate individual dosage.

In infants and children, there is a great urgency to achieve full thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult, as much as 300 mcg (0.3 mg) to 400 mcg (0.4 mg) per day.

In myxedema coma or stupor, without concomitant severe heart disease, 200 to 500 mcg of SYNTHROID **Injection** may be administered intravenously as a solution containing 100 mcg/ml. Although the patient may show evidence of increased responsivity within six to eight hours, full therapeutic effect may not be evident until the following day. An additional 100 to 300 mcg or more may be given on the second day if evidence of significant and progressive improvement has not occurred. Like the oral dosage form, SYNTHROID **Injection** produces a predictable increase in the circulating level of hormone with a long half-time. This usually precludes the need for multiple injections but continued daily administration of lesser amounts intravenously should be maintained until the patient is fully capable of accepting a daily oral dose.

In the presence of concomitant heart disease, the sudden administration of such large doses of L-thyroxine intravenously is clearly not without its cardiovascular risks. Under such circumstances, intravenous therapy should not be undertaken without weighing the alternative risks of the myxedema coma and the cardiovascular disease. Clinical judgment in this situation may dictate smaller intravenous doses of levothyroxine.

SYNTHROID **Injection** by intravenous or intramuscular routes can be substituted for the oral dosage form when ingestion of SYNTHROID **Tablets** is precluded for long periods of time.

How supplied

SYNTHROID (sodium levothyroxine) **Tablets** are supplied as scored, color-coded compressed tablets in 6 concentrations: 25 mcg (0.025 mg)—orange . . . 50 mcg (0.05 mg)—white . . . 100 mcg (0.1 mg)—yellow . . . 150 mcg (0.15 mg)—violet . . . 200 mcg (0.2 mg)—pink . . . 300 mcg (0.3 mg)—green. Depending on strength, these tablets are available in bottles of 100, 500, 1000 and 5000.

SYNTHROID (sodium levothyroxine) for **Injection** is supplied in 10 ml vials containing 500 mcg of lyophilized active ingredient and 10 mg of Mannitol, U.S.P. A separate 5 ml vial containing Sodium Chloride Injection, U.S.P. is provided as a diluent.

Directions for reconstitution

Reconstitute the lyophilized sodium levothyroxine by aseptically adding 5 ml of the Sodium Chloride Injection, U.S.P. to the vial. Shake vial to insure complete mixing. **Use immediately** after reconstitution. Discard any unused portion.

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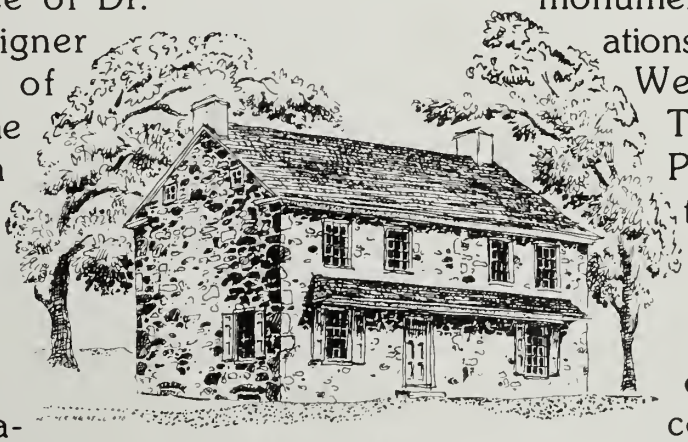
*U.S. Pat. 2,889,363

Give America a Bicentennial Birthday Present

American physicians are cordially invited to join the effort to preserve the birthplace of Dr. Benjamin Rush, Signer of the Declaration of Independence and the "Father of American Medicine" as a gift to the Nation on its two hundredth anniversary.



The Benjamin Rush House, Philadelphia, Pennsylvania

Revolutionary patriot, physician, and social activist, Rush was born in this modest farmhouse, which will be preserved in Philadelphia as a symbol of ideals and goals for which we strive today. This living landmark will serve as a community meeting center and an education and inspirational monument for future generations.

We need $150,000. To date the American Psychiatric Association has raised $25,000. School children, women's clubs, and patriotic citizens have contributed $20,000 to the "doctors' project." Now Pennsylvania's Medical Society invites you to share in preserving this historic medical treasure as your Bicentennial gift.

A. Reynolds Crane, M.D., President
Pennsylvania Medical Society

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Address: _____

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AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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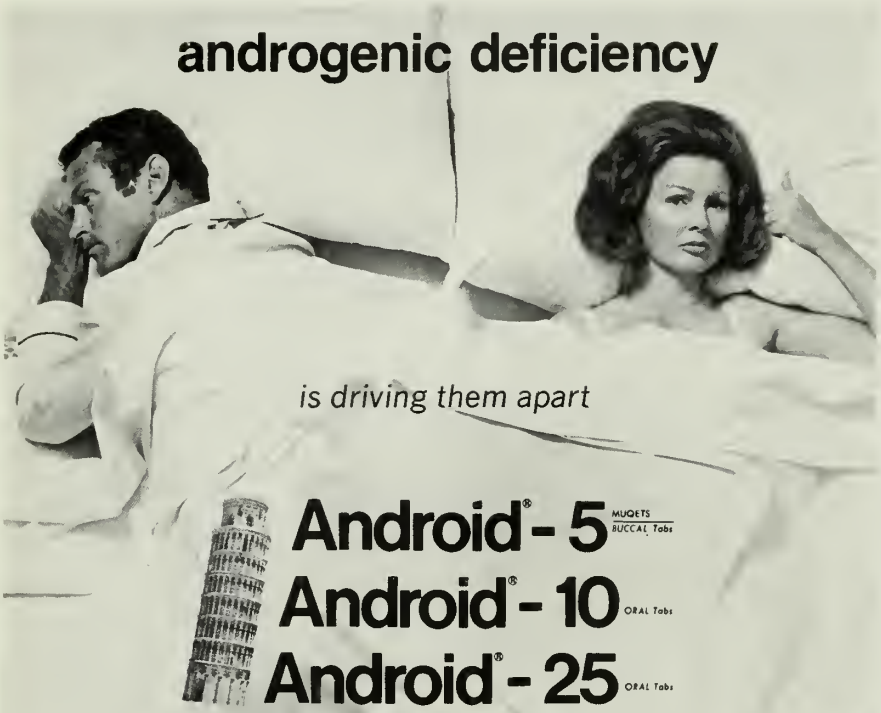

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Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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Thiamine Mononitrate	2.5 mg
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Vitamin B-12	1.5 mcg
Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide	0.075 mg
Calcium (from Dicalcium Phosphate	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 mg
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg

ACTION AND USES — DOSAGE: 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets. Rx only.

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Operative management of renovascular hypertension

HENRY D. BERKOWITZ, M.D., F.A.C.S.

PETER R. McCOMBS, M.D.

BROOKE ROBERTS, M.D., F.A.C.S.

Philadelphia

Dr. Berkowitz is assistant professor of surgery, University of Pennsylvania School of Medicine and assistant chief of the vascular service. He and Dr. McCombs, who is assistant instructor of surgery at the School of Medicine, are presently working on problems of the renin angiotensin system as it affects renal perfusion and function. Dr. Roberts is professor and chief of the vascular service of the University of Pennsylvania School of Medicine and past president of the Philadelphia County Medical Society.

About 5 to 10 percent of the 30 million hypertensive patients in the United States have a potentially surgically curable form of the disease.[6,10,13] Stenotic lesions of the renal arteries constitute the predominant pathologic lesion found in these correctable forms of hypertension. This entity is now being recognized with increasing frequency at most centers treating the hypertensive patient, and a favorable response to surgical intervention has been demonstrated across a broad spectrum of the population.[11,12]

This report concerns our experience in the operative management of renovascular hypertension at the Hospital of the University of Pennsylvania over the past 9 years. It confirms the generally favorable prognosis the vascular surgeon may offer his patient with hypertension secondary to renal artery stenosis and emphasizes the concept that renal function may be preserved in the young hypertensive patient and sometimes even improved by arterial bypass in those with renal parenchymal disease secondary to long standing ischemia.

TABLE I

Distribution Of RVH

	Male	Female	Total	White	Black	Avg. Age
AS	19	4	23	21	2	52.7
FMH	3	12	15	14	1	26.9

TABLE II

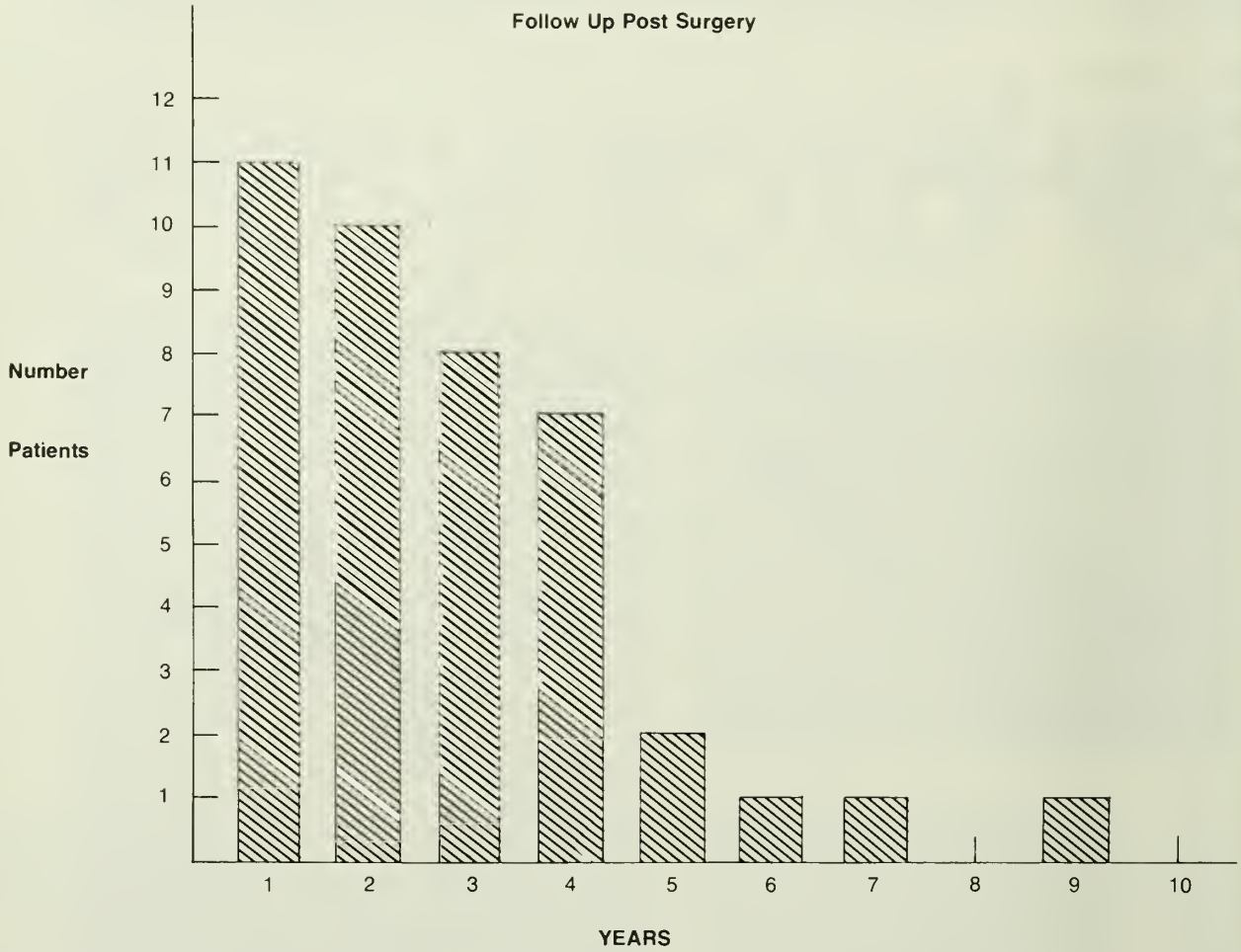
Results Of Surgery

	Cured	Improved	Unimproved
AS	8	15	4
FMH	11	3	1
Total	19(45%)	18(43%)	5(12%)

Methods

From June, 1966 to January, 1975, 38 patients underwent surgery for uncontrolled renovascular hypertension. Four patients were subsequently reoperated upon because of technical failures or progression of disease, making a total of 42 opera-

FIGURE 1



tions. Of these, 7 were nephrectomies and 35 were revascularization procedures.

Results

Followup periods ranged from 2 to 103 months, with an average of 30 months (Figure 1). There were no operative deaths, although 3 patients with advanced arteriosclerotic disease expired during the followup period, from 2 months to 3 years following surgery. Renal artery stenosis was secondary to arteriosclerosis in 23 patients and fibromuscular hyperplasia in 15 (Table I). The majority of the arteriosclerotic patients were white middle age males, while the patients with fibromuscular hyperplasia tended to be young white females. This distribution of disease is entirely consistent with other published series.[4,6,10]

In order to quantitate our results as objectively as possible, we have established 3 categories into which all patients have been stratified, based on their status at the most recent followup examination. We consider an individual "cured" if his blood pressure has fallen to the normal range (diastolic less than 90 mm Hg), and is off all antihypertensive medication. The "improved" patients require antihypertensives to maintain their blood pressure in the normal range or are more easily regulated on a less vigorous antihypertensive regimen than was required preoperatively. "Unimproved" patients are those whose blood pressure remains poorly controlled postoperatively, or those in whom no reduction in medication has been possible. Based on these criteria, 19 patients (45 percent) were cured by surgery, 18 (43 percent) were improved, and 5 (12 percent) were unimproved. As demonstrated in Table II, the cure rate in patients with fibromuscular hyperplasia was superior to that in the arteriosclerotic patients, and 4 of the 5 unimproved patients came from the arteriosclerotic group. Nevertheless, 23 of 27 operations on patients with arteriosclerotic renal artery stenosis produced cure or improvement.

Table III confirms the generally accepted fact that the best results are seen in patients whose history of

TABLE III

Duration Of Hypertension

	Total	Cured	Improved	Unimproved
Less Than 1 Year	13	9 (69%)	4 (31%)	0
1 Year To 3 Years	10	6 (60%)	3 (30%)	1 (10%)
Over 3 Years	11	3 (27%)	6 (54%)	2 (18%)

TABLE IV

Type Of Operation

	Cured	Improved	Unimproved
Nephrectomy	2	4	1
Endarterectomy	1	1	1
Segmental Resection	1	1	0
Vein Graft			
Unilateral	12	10	2
Bilateral	0	1	0
Prosthetic Graft			
Unilateral	2	1	1
Bilateral	1	0	0

hypertension is short. While 69 percent of patients with high blood pressure diagnosed less than 1 year prior to operation were cured (and the balance improved), only 27 percent of those with long standing hypertension (greater than 3 years) could be cured of their disease, while 18 percent were unimproved. However, a long duration of hypertension should not be an absolute contraindication to surgery since 7 of our patients who had hypertension for 6 years or more were cured or improved.

The type of operation performed in each case was tailored to the individual needs of the patient. However, as the series evolved, the autogenous aortorenal saphenous vein bypass graft became the procedure of choice for uncomplicated renal artery stenosis, based on technical ease and superior overall clinical results. Revascularization procedures of several types were performed early in the series, as shown in Table IV, including endarterectomy with vein patch angioplasty and segmental resection of diseased arterial segments with primary end-to-end anastomosis. Bypass grafts of prosthetic woven dacron were generally performed in conjunction with distal aortic replacement for abdominal aortic aneurysms or aortoiliac occulsive disease.[9] Nephrectomy has been reserved only for those cases where total absence of renal function, infarction, or end stage parenchymal disease are demonstrated in the preoperative evaluation.[2,13,15]

The technique of the aortorenal saphenous vein bypass is essentially that advocated by Dean and Foster.[10] A reversed, 5 cm segment of proximal saphenous vein, gently distended and irrigated, is anastomosed first to the aorta and then to the renal artery after Heparin (5,000 units) and Mannitol (50 mg) have been given. Both anastomoses are performed with fine prolene suture and great care is taken to avoid kinking or twisting of the graft due to excessive length or poor positioning. Right-sided grafts have usually been brought retrocaval, and those on the left side are carried behind the renal vein.

Table IV catalogs clinical results based on the type of operation performed, and demonstrates the nearly uniform effectiveness (92 percent) of the saphenous vein bypass graft in curing or improving patients with renovascular hypertension. Two failures which occurred, 1 thrombosis and 1 stenosis, were results of technical misadventure. One patient subsequently benefited from nephrectomy.

Discussion

Selection of patients for surgery was based on rapid sequence intravenous pyelography, selective renal arteriography, and peripheral and renal vein renin assays.[1,2,4] Of the patients in our series, 71 percent had lateralizing signs of ischemia on intravenous pyelogram (a significantly smaller renal shadow, delayed nephrogram, or evidence of nonfunction). In 100 percent the arterial stenosis was demonstrated in either antero-posterior or special oblique projections on selective renal arteriograms.[8] Twenty-nine percent of the patients who had normal IVPs were found to have significant renal artery stenosis on arteriogram, and all of these were either cured or improved.[2,10] In 75 percent of patients in whom renal venous renin levels were measured, either by bioassay or immunoassay techniques, there was strong evidence of unilateral ischemia.

Due to the multitude of physiologic and pharmacologic factors capable of augmenting or suppressing the release of renin by the kidney, we have tended to emphasize the ratio of renin release by the diseased kidney (R_D) compared to the nondiseased kidney (R) during preoperative evaluation, rather than the individual renin concentrations alone.[4] We have interpreted the ratio $R_D/R \geq 1.5$ as evidence of significant activation of the renin angiotensin mechanism by the diseased kidney. Likewise, we have interpreted a ratio between renin from a nondiseased kidney and the distal inferior vena cava (IVC) of less than 1 to be evidence of suppression of the renin angiotensin axis in the nondiseased kidney. From this model, one would expect patients who demonstrated an R_D/R ratio of ≥ 1.5 and R/IVC ratio of less than 1 to have the greatest probability of cure, while patients with the opposite condition to expect the poorest prognosis.

The results in Table V indicate that favorable renin ratios ($R_D/R \geq 1.5$) were associated with a 90 percent cure or improvement rate. However,

TABLE V

Renal Vein Renin Ratios

				Cured	Improved	Unimproved
$\frac{R_D}{R}$	≥ 1.5			11	8	2
$\frac{R_D}{R}$	≥ 1.5 and	$\frac{R_D}{IVC}$	< 1.0	5	3	0
$\frac{R_D}{R}$	< 1.5			4	2	1
$\frac{R_D}{R}$	< 1.5 and	$\frac{R}{IVC}$	> 1.0	4	1	1

TABLE VI

Postoperative Studies

	Cured	Improved	Unimproved
Arteriogram Patency	5	3	1
Stenosis / Occlusion	0	2	2
Peripheral Renin			
> 1.2	3	2	0
≤ 1.2	7	2	0

even in the 7 patients where R_D/R was less than 1.5, the cure and improvement rate was still 85 percent. Consideration of the R/IVC ratio did not give any further predictive information. While it would appear that augmented renin release from the involved kidney was not a reliable indicator of potential surgical benefit, it is interesting to note that the majority of patients in our series (21/28) had an elevated renin ratio. In the postoperative period, 14 patients had peripheral renin levels drawn while they were supine, off all antihypertensive medication and on an adlib sodium diet. Those patients with renin levels of 1.2 x 10^{-4} Goldblatt units per milliliter or less (normal less than 2.0 x 10^{-4} Goldblatt units) had a greater than twofold likelihood of being cured of their hypertension than patients whose postoperative peripheral renin level was 1.3 x 10^{-4} G.u./ml or higher.[3]

Postoperative arteriograms were obtained in 13 patients one week to three years postoperatively. Previous reports have demonstrated that technical errors committed at surgery are likely to be manifest early in the postoperative period as sustained hypertension due to anastomotic stenosis or graft thrombosis.[7,14] In our series, as shown in Table VI, there were 4 graft complications, 1 thrombosis and 3 stenoses, for a technical complication rate of 12 percent.

Of our patients, 29 percent underwent renal revascularization procedures for the dual indication of correction of hypertension and preservation of renal function.[4,5,10] This group includes those individuals with bilateral renal artery stenosis, patients with a hypoplastic nonfunctioning kidney and contralateral renal artery stenosis, young patients with tight (90 percent) stenosis for whom eventual renal deterioration seemed to be virtually certain even though hypertension could be controlled, and 1 patient with arterial stenosis and impaired renal function in a solitary kidney. Table VII displays the results of bypass surgery in this group. All but 2 of the 11 patients had arteriosclerotic lesions and in every case hypertension was improved or cured. No patient has exhibited deterioration in renal function during the followup period; 3 patients in whom we intended to preserve normal renal function have remained normal; and 5 patients with impaired renal function preoperatively have demonstrated 10 to 50 percent reduction in serum blood urea nitrogen and creatinine values since surgery. One of these now has normal renal function.

We believe renal artery bypass grafting has definite applications in arresting progressive renal failure when it is related to chronic ischemia, in maintaining normal renal function in young hypertensive patients with severe stenosis, and in reversing renal impairment in certain high risk patients. Combining careful patient selection, precise attention to technical details and close postoperative followup, renal artery bypass grafting represents a valid and favorable approach to many hypertensive patients with renal artery stenosis. Morbidity and mortality have become acceptably low and the therapeutic gain, especially in patients with high blood pressure of recent onset, is gratifying. □

TABLE VII

Indications for Surgery

Hypertension Alone **31**
Hypertension and Preservation of Renal Function **11**

Patient	Age	Dx	Hypertension	Renal Function Preop / Postop	
1	60	AS	Improved	normal	normal
2	58	AS	Improved	impaired	improved
3	82	AS	Improved	impaired	improved
4	52	AS	Improved	impaired	improved
5	33	FMH	Cured	normal	normal
6	60	AS	Cured	impaired	normal
7	57	AS	Improved	impaired	unchanged
8	50	AS	Improved	impaired	unchanged
9	49	AS	Improved	impaired	unchanged
10	66	AS	Improved	impaired	improved
11	52	FMH	Improved	normal	normal

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A case report and review of the literature

Cystadenocarcinoma of the pancreas

EMERSON L. KNIGHT, JR., M.D. PAUL A. WENGERT, JR., M.D. JOSEPH A. RICCI, M.D.

Harrisburg

Cystadenocarcinoma of the pancreas is a rare entity. The first case was reported by Lichtenstein in 1934.[1] Cullen, *et al,* reported 17 cases in 2,400,000 admissions at the Mayo Clinic[2] and Warren and Hardy reported 17 cases over a 40 year period at the Lahey Clinic.[3] Sommers and Mesissner in an excellent review of unusual carcinomas of the pancreas described only two cystadenocarcinomas out of 142 post mortem cases of pancreatic carcinomas.[4]

The purpose of this paper is to review the literature on cystadenocarcinomas of the pancreas and to present a case report of a sixty year old male who presented with an unusual case of obstructive jaundice.

Report of a case

This sixty year old white male was admitted to Polyclinic Hospital with a two week history of dark urine, light clay-colored stools, and yellow skin and eyes. He admitted to a four pound weight loss. He denied any pruritus, previous abdominal trauma, abdominal pain, nausea, vomiting, excessive ingestion of alcoholic beverages, or known exposure to hepatitis or hepatotoxic drugs. The past medical history, social history, and remainder of the review of systems were essentially negative.

Physical examination revealed a thin male with obvious jaundice and no acute distress. The liver edge was palpable five cm below the right costal margin, and the gallbladder was distinctly palpable but nontender.

Laboratory results revealed a total bilirubin of 19.2 mg percent alkaline phosphatase of 1500 mu/ml, serum glutamic oxaloacetic transaminase of 208 mu/ml, prothrombin time of 14.2 seconds (patient) 11.6 seconds (control), and blood glucose of 118 mg percent. Blood count, urinalysis, electrolytes, lactate dehydrogenase, total proteins, cholesterol, urine and serum amylase, and serum lipase were all within normal limits.

Chest x-ray, intravenous pyelogram, liver and spleen scan, and barium enema were all normal. An upper gastrointestinal examination revealed left and anterior displacement of the stomach (Figure 1) as well as prominent folds along its medial and posterior aspects (Figure 2).

The patient was taken to the operating room and explored through a right paramedian incision. A 12 cm mass was found located in the head and body of the pancreas compressing the descending portion of the duodenum. The common bile duct and gallbladder were markedly dilated but contained no calculi. The surface of the pancreas was very hard. When biopsied a cystic cavity was entered which produced clear, stringy mucoid material. Biopsies of the pancreas and pancreatoduodenal lymph nodes were negative for malignancy by frozen section. In view of the common duct and duodenal obstruction, a double bypass was performed—cholecystojejunostomy and gastrojejunostomy.

Permanent sections of the biopsies taken revealed innocuous appearing villiform papillary structures of benign columnar mucinous glands characteristic of a benign cystadenoma. (Figure 3) However, on deeper sections there was an abrupt transformation into a papillary neoplasm with increased branching, pleomorphism, and hyperchromaticity consistent with a cystadenoma that had undergone malignant change. (Figure 4) Surgical removal of the tumor would have required a total pancreatectomy and duodenectomy. The procedure was technically possible, but

Figure 1–Upper gastrointestinal examination showing anterior displacement of stomach by a retrogastric mass.

Figure 2–Upper gastrointestinal examination showing prominent folds along the posterior aspect of the stomach.

This paper was prepared by the department of surgery at Polyclinic Hospital, Harrisburg. Dr. Knight is currently a resident in urology at the University of West Virginia Medical Center. Dr. Wengert is an associate in the department of general surgery and Dr. Ricci is chief in the department of hematology and oncology at Polyclinic Hospital.

the patient refused further surgery.

Postoperatively the patient did well. The liver enzymes and bilirubin returned to normal. He readily regained his appetite and was discharged on the tenth postoperative day. Prior to discharge he was evaluated by our oncologist and placed on a regimen of Methotrexate, 5-Fluorouracil, and Cyclophosphamide.

Discussion

Glenner and Mallory in 1956 postulated the concept that cystadenomas and cystadenocarcinomas of the pancreas arise from the duct epithelium. They considered cystadenomas of the pancreas precancerous lesions.[5] For this reason some authors advocate wide excision of cystadenomas.[3]

Our patient was unusual in that he presented with obstructive jaundice. In our review only Cullen reported patients who were jaundiced at operation (5 out of 17).[2] The vast majority of patients present with vague abdominal pain, significant weight loss, or an abdominal mass. The absence of pancreatitis, trauma, alcoholism, and drug addiction should make one consider the possibility of a malignancy rather than pseudocyst.[3,6]

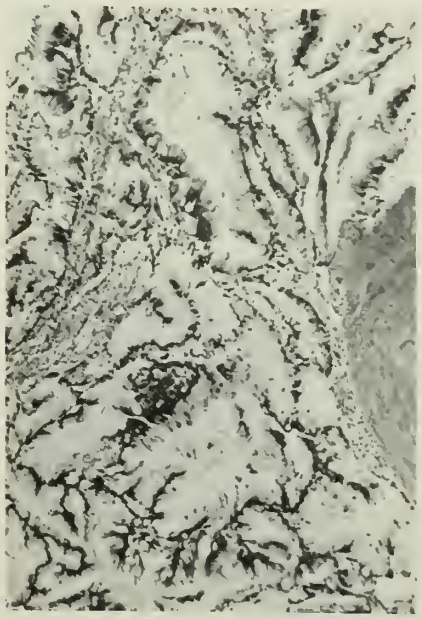

Figure 3–Superficial sections of pancreatic biopsy showing innocuous appearing benign columnar mucinous glands characteristic of a cystadenoma.

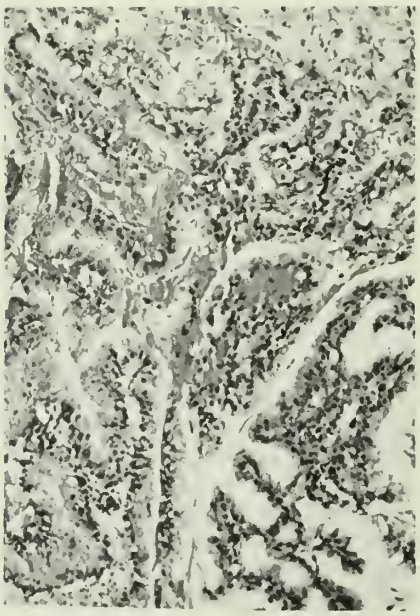

Figure 4–Deeper section of pancreatic biopsy showing malignant transformation into a cystadenocarcinoma

The diagnosis may be aided with an upper gastrointestinal series which often shows extrinsic pressure on the stomach. A curvillinear calcification in the left upper quadrant of the abdomen on an intravenous pyelogram along with a medial displacement of the stomach on an upper gastrointestinal series could suggest the diagnosis.[7]

Females are affected two to three times more frequently than males, and the age range varies from the third to the eighth decade with the average age being in the fifth and sixth decades.

The lesion seems to be distributed evenly in the head, body, and tail of the pancreas. Unlike adenocarcinoma metastases occur late. Metastases occur locally to the peritoneum, regional lymph nodes, and the liver. Warren has also reported metastases to the transverse mesocolon and kidney.[3]

Associated findings reported include cholelithiasis, pancreatitis, and diabetes mellitus. Cullen reported an asymptomatic jejunal diverticulum, and Campbell, *et al.*, reported two cases of upper gastrointestinal hemorrhage associated directly with the lesion.[8]

The treatment of choice is wide excision of the tumor which includes a rim of normal pancreatic tissue and in some cases this means a pancreatoduodenectomy. With this treatment long term survival may be achieved in 50 percent of cases. Staged pancreatectomies[2] and staged pancreatoduodenectomies have been reported with survivals from 3 and one half to 10 years.

Shulman, *et al.*, reported a survival of 5 years and 10 months in an elderly patient with widespread disease after internal drainage of cystadenocarcinoma.[9] However, lesser procedures such as bypass and internal or external drainage procedures should be limited to the poorer risk and elderly patients.

Chemotherapy has been used as adjuvant therapy in non-resectable adenocarcinomas of the pancreas.[10] Combinations of chemotherapeutic agents acting at different steps in DNA syntheses or altering the DNA molecule appear to provide therapeutic effects superior to those achieved alone or with other combinations.[11] There have been no reports of these agents being used in treating cystadenocarcinomas.

Radiotherapy has been used for palliation in these tumors but generally yield poor long term results.

While surgery remains the best treatment available, chemotherapy and radiotherapy may be useful in certain cases. □

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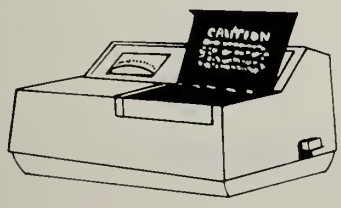

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obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Francis A. Aaron,** Pittsburgh; Jefferson Medical College, 1929; age 72; died June 28, 1975. His wife and a son survive him.

• **Richard C. Allsopp,** Evans City; University of Maryland School of Medicine, 1943; age 57; died August 19, 1975. Dr. Allsopp served as president of the Butler County Medical Society in 1959 and was a member of the society's board of censors from 1970-72. His wife, three daughters, and a sister survive him.

• **Anthony C. Bonatti,** New Kensington; Jefferson Medical College, 1923; age 76; died August 10, 1975. He is survived by his wife, a son, William D. Bonatti, M.D., and a sister.

• **John H. Bucher,** Selinsgrove; Temple University School of Medicine, 1953; age 52; died August 4, 1975. Information regarding survivors is not available.

• **John Karl Grau,** Beaver Falls; University of Pennsylvania School of Medicine, 1940; age 58; died August 6, 1975. Surviving are his wife, three sons, and three brothers.

• **Martin Karle Hessen,** Lancaster; University of Berlin, 1928; age 69; died August 10, 1975. He was acting director of psychiatry at St. Joseph Hospital. He is survived by his wife, five sons, and two daughters.

• **Carl C. Kessler,** Lancaster; Jefferson Medical College, 1940; age 61; died July 24, 1975. His wife, two sons, two daughters, and a sister survive him.

• **Thomas H. Murphy,** Pittston; Temple University School of Medicine, 1932; age 80; died August 31, 1975. There are no known immediate survivors.

• **Franklin F. Osterhout,** Niantic; Jefferson Medical College, 1928; age 73; died August 9, 1975. Surviving are his wife, two daughters, and a sister.

• **Ward D. O'Sullivan,** Darby; Cornell University Medical School, 1942; age 58; died August 12, 1975. He was chairman of the department of surgery at the Mercy Catholic Medical Center and clinical professor of surgery at Jefferson Medical College. Dr. O'Sullivan was a diplomate of the American Board of Surgery and a fellow of the American Association of Surgical Trauma and the American College of Surgeons. Dr. O'Sullivan received Fordham University's Encaenia Award (1958) and the Achievement Award in Medicine (1962) of Fordham's alumni association. His wife, three daughters, and a son survive him.

• **Owen J. Toland,** Wynnewood; University of Pennsylvania School of Medicine, 1924; age 78; died August 14, 1975. He was chief of obstetrics for 25 years at Episcopal Hospital, Philadelphia, and served as president of the Obstetrical Society of Philadelphia 1958-59. His wife and three sons survive him.

• **Francis D. Ventura,** Norristown; Tufts University School of Medicine, 1922; age 76; died August 24, 1975. He is survived by his wife.

• **George L. Wessels,** Elizabethtown; University of Pittsburgh School of Medicine, 1927; age 79; died May 28, 1975. There are no survivors.

Valerie H. Green, Phoenixville; Temple University School of Medicine, 1943; age 57; died August 27, 1975. Her father, a son, and a sister survive her.

Eugene M. Laci, Greensburg; University of Pittsburgh School of Medicine, 1961; age 39; died August 13, 1975. He is survived by his wife, a son, a daughter, his parents, and a brother.

Paul A. Rothfuss, Williamsport; University of Maryland School of Medicine, 1923; age 81; died August 13, 1975. He served as state deputy secretary of health from 1936-40. Three sons, two brothers, and a sister survive him.

Jacob S. Sherson, Merion Station; Temple University School of Medicine, 1931; age 68; died August 3, 1975. His wife, two sons, three sisters, and a brother survive him.

Howard M. Wisotzkey, Glenshaw; University of Maryland School of Medicine, 1961; age 40; died August 17, 1975. He was assistant professor of pathology at the University of Pittsburgh School of Medicine. His wife, two daughters, a son, and his mother survive him.

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Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

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Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.
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Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
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Retroperitoneal fibrosis—a review

ALAN S. PETERSON, M.D.

Philippi, West Virginia

For his presentation of this paper, Dr. Peterson received the Klemmer Award of Lancaster General Hospital, where he was a resident in family practice. Currently Dr. Peterson is director of the family practice department, Myers Clinic, Philippi, West Virginia.

Retroperitoneal fibrosis is a relatively rare protean disease, making effective evaluation difficult. It was first described by the French urologist, Albarran,[1,2] in 1905. No further mention is found in the literature until 1935 by Marion.[3] In 1948, Ormond published the first account in the English literature.[4] Since then, it has been found increasingly more often in adults. Children appear to be rarely affected by the disorder as only five cases have been reported.[5,6,7,8,32] Three quarters of the cases of retroperitoneal fibrosis occur between 40 and 60 years with males predominating.

Clinical findings

The clinical picture of retroperitoneal fibrosis is secondary to the pressure produced by the fibrotic process. Pain is the commonest complaint occurring chiefly in the flank, lumbosacral area and lower abdominal quadrants. The pain in the flank may be colicky or crampy in quality while the lower abdominal pain is usually colicky. At times, pain in the leg referred to the inner upper thigh is due to pressure on the genitofemoral nerve.

Weight loss is the next most common clinical finding. It occurs in one-third of the cases.[10] Nausea, vomiting, and malaise follow in frequency. The urological manifestations most often encountered are frequency and anuria. Edema of the lower legs or scrotum secondary to lympgangitic or inferior vena caval obstruction is found in 10-20 percent of cases. Fever can be present in the same frequency.

Physical findings

Hypertension is a common finding occurring as high as 40-60 percent of cases by some investigators.[9,13,14] Costovertebral angle tenderness is the physical sign next most commonly elicited.[11,12] Masses are infrequently palpable and usually represent a retroperitoneal neoplasm or hydronephrotic kidney.

Laboratory values

Sedimentation rates are often elevated[9] and seem to reflect activity of the fibrotic process. From 40-50 percent of urinalyses are abnormal enough to suggest the presence of a urinary tract disease. Seldom, however, do urine cultures grow pathogenic bacteria.

Hypochromic, microcytic anemia[15,16] (usually between 9 and 11 gm of hemoglobin) is present in nearly every case and sometimes is associated with mild to moderate eosinophilia. Blood chemistry abnormalities usually depend on the se-

verity of uremia from bilateral ureteral obstruction.

X-ray findings

The excretory urogram is the x-ray of choice in determining the possible presence of this process as 97 percent of cases show some degree of involvement. Hydronephrosis, medial deviation of the ureter, and extraureteral obstruction are commonly found. Narrowing as well as medial deviation is more common in the middle third of the ureter. This narrowing is a gradual tapering to the obstruction. Retrograde urography may be useful if the excretory urogram is contraindicated or the urinary tract fails to concentrate the dye for adequate visualization.

Lymphangiography may disclose collateral lymphatic filling, irregular nodal filling defects, reflux into lymphatics not normally visualized, and inability to visualize vessels above the fourth lumbar vertebra.[9,17]

Pathology

Grossly, the fibrosis appears as a prolific sheet of hard, pink-to-white fibrous tissue, depending on maturity of the mass. The fibrotic process may surround or invade any retroperitoneal structures in its path.

This process usually involves the retroperitoneal area although less common locations are the mediastinum, intestinal mesentery, gall bladder, and connective tissues surrounding the spleen and bile ducts.

Microscopically, retroperitoneal fibrosis follows stages of developing nonsuppurative inflammation in the fibrous tissue, ranging from a subacute phase to polymorphonuclear, plasma cell, or lymphocytic infiltration to complete hyalinization. These phases may be seen in different areas of the same specimen. A moderate amount of vascularity with fat involvement and replacement is common. Multiple dilated lymph vessels have been observed.[18]

Treatment

No long term successful therapy has been found for this enigmatic process. The two modalities most often tried are surgery and corticosteroids. Surgical release of fibrous bands that cause ureteral obstruction is sometimes necessary for continuation of renal function. Nephrostomy or ureterostomy are sometimes necessary. Successful results have been seen with corticosteroids.[19,20,21] Reports vary on the value of steroids.[22,23,24] No response and even progression are possible while using steroids.[25,26,27] Spontaneous regression has been described.[28,29]

Prognosis

A good prognosis is determined by early recognition, extent of renal impairment and response to treatment. Late diagnosis and inadequate treatment will increase morbidity. Insufficient studies to date make accurate prognostication difficult.

Etiology

The cause of retroperitoneal fibrosis is obscure. Retroperitoneal fibrosis has no known cause but is associated at times with systemic diseases that are often felt to be due to auto-immunity. Disorders, such as Henoch-Schoenlein purpura,[6,7] sclerosing cholangitis, Riedel's struma, lupus erythematosis, membranous glomerulonephritis, periarteritis nodosa and Raynaud's disease have been reported in association with retroperitoneal fibrosis. Retroperitoneal fibrosis has also been reported in chronic hereditary lymphedema.

Methysergide maleate (Sansert) therapy for migraine headache in a relatively few cases has been complicated by the development of retroperitoneal fibrosis[30] suggesting an allergic factor as a cause for the disorder.

Infectious causes have been implicated by the occasional association of a past history of lymphangitis[6,18,32] in the recent or remote past originating in the intestine, pelvic organs or lower extremities. □

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Proceedings
Special Session of the House of Delegates
Camp Hill, Pennsylvania
July 2-3, 1975

(Secretary's Note: Affirmative action by the House on the recommendations of the Reference Committee was taken unless otherwise specifically reported.)

The Opening Session of the House, July 2, 1975

The speaker, John B. Lovette, M.D., called the House to order at 1:00 p.m. Wednesday, July 2, 1975 in the Grand Ballroom of the Penn Harris Motor Inn, Camp Hill. The Speaker first called on David S. Masland, M.D., Cumberland County, who delivered a eulogy in memory of John H. Harris, Sr., M.D. The House rose to observe a moment of silence. The chair then called on Reverend Laurie Roberts, Hospital Chaplain at Harrisburg Hospital and Consultant to the Committee on Medicine, Religion and Bioethics, who offered the invocation. John B. Lovette, M.D., Speaker of the House, then called on J. Campbell Martin, M.D., Columbia County, chairman of the Committee on Credentials, who reported that a quorum was present.

Reading of the Official Call

D. Ernest Witt, M.D., vice speaker, read excerpts from the Official Call contained in a letter dated June 2, 1975 from G. Winfield Yarnall, M.D., Dauphin County, secretary, which states in part:

"The Board of Trustees and Councilors of the Pennsylvania Medical Society determined on May 22 to call a special session of the House of Delegates.

"This Official Call is issued pursuant to Article VII, Section 2 of the Constitution.

"The special session will convene at the Penn Harris Motor Inn, Camp Hill, Pa., Wednesday, July 2, 1975 at 1:00 p.m. The second and concluding session will begin at 9:30 a.m., Thursday, July 3, 1975.

"The purpose of the session is to review the progress of the professional liability insurance crisis and the Society's response to it; the current status and future prospects of remedial legislation; and to formulate policy and actions for the Society's further response to the crisis."

Report of Special Committee on Rules

William A. Shaver, M.D., Lebanon County, chairman of the Special Committee on Rules, presented the following report:

"Mr. Speaker, and Members of the House of Delegates:

"The Committee on Rules met and unanimously approved the adoption of the Standing Rules of the House of Delegates of the Pennsylvania Medical Society as printed in a report presented in the delegates' packets, with the exception that Standing Rule No. 5 be deleted from the report since it is irrelevant for this special House meeting. **Mr. Speaker, I recommend that the Standing Rules of the House be adopted as presented with the amendment to delete Standing Rule No. 5."**

Standing Rule No. 1 Order of Business, Special Session

The first meeting of the House shall contain the items listed below, with the understanding that the Speaker may determine their order.

First Meeting:

1. Call to Order
2. Invocation
3. Credentials Committee Report
4. Reading of Official Call
5. Report of Special Committee on Rules
6. Announcements
7. Address of the president, A. Reynolds Crane, M.D.
8. Introduction of Reports and Resolutions
9. Introduction of Late Resolutions and Reports
10. Recess

The second meeting of the House will contain the items listed below with the understanding that the Speaker may determine their order:

Second Meeting:

1. Call to Order
2. Report of Committee on Credentials
3. Report of Reference Committee
4. Announcements
5. Adjournment

Standing Rule No. 2 Procedure for Submitting Resolutions (Revised for Special Session)

As mandated in Section 3 of Article VII, of the constitution, resolutions submitted for consideration by the Special Session of the House must pertain to the matter expressly stated in the Call for the Special Session.

Resolutions may be submitted at any time prior to the special meeting of the House. Those received prior to seven days before the session shall be duplicated and included in the mailing of agenda materials. Those which

arrive after the mailing but prior to the opening of the House of Delegates shall be distributed at registration and require two-thirds favorable vote of the members of the House present and voting at the first meeting of the House to become the business of the House. Any resolutions submitted after the House of Delegates has convened will require a three-fourths favorable vote of the members of the House present and voting to become the business of the House. The foregoing rule shall not apply to substitute resolutions.

All resolutions must be introduced by a member of the House of Delegates acting in his own behalf or for the component county medical society or specialty he represents.

Resolutions emanating from, and approved by, the Board of Trustees may be submitted directly to the House of Delegates at any time prior to or during the session, at the discretion of the speaker.

All resolutions are to be submitted to the secretary of this Society in duplicate and should include the name of the author.

The Speaker of the House of Delegates during the session of the House shall have the right to declare any resolution out of order in accordance with the principles of Sturgis Standard Code of Parliamentary Procedure.

Standing Rule No. 3

The legal counsel and the executive vice president of this Society, or their designated representatives, shall review without the right of censorship each reference committee report and inform the chairman of the Reference Committee and the speaker of any possible implicating statements or recommendations. This rule shall not prevent a Reference Committee from submitting any reports that it deems proper.

Standing Rule No. 4 Actions of House in Effect until Altered by House

Any resolution or other action of this House of Delegates shall remain in effect until countermanded or altered by the House of Delegates unless otherwise specified in the body of the original action taken by the House of Delegates.

Standing Rule No. 5 Procedure Regarding the Bullet Ballot

(Secretary's Note: This Standing Rule relates to balloting procedures for election of officers and was thus deemed irrelevant to the business of this special session.)

Standing Rule No. 6

At the option of the speaker, the chair will not recognize the motion to vote immediately or terminate debate as being "in order" if it is added at the conclusion of a significant discussion of the immediately pending question, or at least until one additional person waiting to speak has also had the opportunity to discuss the immediately pending question. Therefore, if the request to terminate debate is made at the conclusion of a significant discussion and declared "out of order" the motion would be considered "in order" after the opportunity had been given for at least one additional speaker of opposite persuasion to discuss the immediately pending question, in order for the House to hear both sides of every issue which comes to the floor for consideration.

Announcements

Dr. Lovette drew the attention of the House to the membership of Reference Committee A, as reported on a list contained in the delegates packet. He pointed out that John Y. Templeton, III, M.D., would be unable to serve on the Reference Committee and that John Helwig, Jr. M.D., Philadelphia County, had agreed to serve in Dr. Templeton's place.

Dr. Lovette then read a statement prepared by Mrs. Raymond C. Grandon, president of the Woman's Auxiliary to the Pennsylvania Medical Society. This reported the projects undertaken by the Woman's Auxiliary in support of Society sponsored H.B. 805 and that as a result of the auxiliary's efforts, nearly 15,000 letters were mailed to the Legislature.

Address of the President

A. Reynolds Crane, M.D., Philadelphia County, president, gave a comprehensive report to the special session, reviewing the history of the professional liability insurance crisis, its present status, attempts being made by the Society to correct the situation, and their possibilities of success. Recommendations for action contained in Dr. Crane's speech were referred to Reference Committee A.

(Secretary's Note: Dr. Crane's address was published in the August issue of PENNSYLVANIA MEDICINE.)

Announcements

The speaker drew the delegates' attention to the sensitive nature of much that would be discussed, and the possible necessity to move from the usual open session of the House into either closed or executive session. He reviewed a closed session as described in Chapter III of the Society's Bylaws as "restricted to members of this Society, its legal counsel and members of the staff of the Society and component societies." An executive session, specified by the same section, is "Restricted to members of the House of Delegates, legal counsel, and such members of the staff of the Society as are necessary for the proper functioning of the House." Dr. Lovette announced that if the need for either a closed or executive session became apparent, the chair would call for a motion to that effect.

Acceptance of Reports and Resolutions

The materials in the delegates' packets were accepted as the official business of the House. This consisted of the following:

Report to the Special Session of the House of Delegates, submitted by the Board of Trustees and Councilors, June 25, 1975

Resolution 75-S-1: Statewide Restriction of Medical Services

Resolution 75-S-2: Injunction for Insurance Premium Roll Back
Resolution 75-S-3: Medical Review Panel of the Patients Compensation Board
Resolution 75-S-4: Endorsement of Defensive Medicine
Resolution 75-S-5: Premium Roll Back
Resolution 75-S-6: Board of Trustees and Councilors and High Risk Specialists
Resolution 75-S-7: Support of HB 805
Resolution 75-S-8: Rollback of Malpractice Premiums
Resolution 75-S-9: Malpractice
Resolution 75-S-13: Passage of HB 805

Introduction of Late Resolutions

The following resolutions were received after the cut-off date of seven days prior to the special session, and required a two-thirds vote of the House to make them the business of the House.

Resolution 75-S-10: PMS Contingency Plan for Emergency Medical Care
Resolution 75-S-11: Alternatives to Slowdowns
Resolution 75-S-12: Support of H.B. 805
Resolution 75-S-14: The Physician's Commitment to Patients and the Physician's Practice Rights
Resolution 75-S-15: "Freeze" on Insurance Premiums
Resolution 75-S-16: Support of HB 805
Resolution 75-S-17: Hearing Before State Insurance Department
Resolution 75-S-18: Release of Durkin Report
Resolution 75-S-19: Change in Method of Malpractice Insurance Suits
Resolution 75-S-20: Surcharge on All Bills for Service Rendered
Resolution 75-S-21: Cumberland County Support of Necessary Slowdowns
Resolution 75-S-22: PMS Joining Member-Defendants in Counterclaim for Abuse of Process
Resolution 75-S-23: Deferral of Medical Treatment
Resolution 75-S-24: Malpractice Insurance Corporation Established and Administered by Pennsylvania Medical Society
Resolution 75-S-25: Support of HB 805
Resolution 75-S-26: Support of HB 805
Resolution 75-S-27: Restriction of Non-Essential Services
Resolution 75-S-28: Poll of Argonaut Insured Physicians
Resolution 75-S-29: Extreme Defensive Medicine
Resolution 75-S-30: Malpractice Crisis

(Secretary's Note: All the above listed resolutions received the necessary two-thirds vote and were accepted as business of the House.)

Announcements and Recess

Following the introduction of late resolutions the speaker reminded the delegates of the councilor district breakfast caucuses the following morning. He pointed out that the Reference Committee report would be ready at that time for review by the caucuses.

The speaker presented a suggestion that at the conclusion of Thursday's meeting the House recess rather than adjourn. This would give the House the option of calling another special session on short notice, without the 30 day period needed to call a regular special session. Dr. Lovette pointed out that this would give notice to all interested parties that the Pennsylvania Medical Society considers the crisis to be so severe that we are ready to meet at any time to take further actions toward solving the crisis.

At the conclusion of these announcements, the House recessed at 2:10 p.m. At 2:30 p.m. Reference Committee A began its hearing in the Grand Ballroom. The hearing concluded at 6:30 p.m.

Second Session of the House, July 3, 1975

The second session of the House was called to order at 9:42 a.m. Thursday, July 3, 1975 in the ballroom of the Penn Harris Motor Inn, Camp Hill, Pennsylvania. J. Campbell Martin, M.D., Columbia County, chairman of the Committee on Credentials, reported a quorum present.

The chair recognized William Y. Rial, M.D., Delaware County, past speaker of the House of Delegates and currently vice speaker of the AMA House of Delegates. Dr. Rial read a communication from James H. Sammons, M.D., executive vice president of the AMA. This reported that a three judge panel of the Circuit Court of Appeals upheld Judge Hoffman's preliminary ruling staying the Government from implementing its proposed utilization review regulations. Dr. Rial announced that there would be a court hearing on the subject July 10.

Report of Reference Committee A

The speaker recognized Robert Poole, III, M.D., Chester County, chairman of the Reference Committee. He presented the following report of the committee:

"Mr. Speaker and members of the House of Delegates: Your Reference Committee has considered all of the reports and resolutions listed in the index.

"Reference Committee A has given consideration to the resolutions prepared by the county medical societies of the Commonwealth of Pennsylvania and has determined that the recommendations represent a sincere concern for the well-being of the patients who are the object of the health care delivery system. The resolutions clearly reflect a desire on the part of physicians to preserve high quality medical care. The quality of this care is jeopardized by the malpractice crisis well known in the State of Pennsylvania and across the nation, and it is apparent to the committee that only corrective legislation, as ideally provided for in the Pennsylvania Medical Malpractice Reform and Patient Compensation Act, also known as House Bill 805, will correct the situation. The content of our report is colored by the apparent reluctance of the government of the State of Pennsylvania to promptly and definitively enact legislation that will meaningfully correct the abuses that have caused the aforementioned crisis. It is with these factors in mind that physicians must pursue firm methods in accomplishing a state of affairs in Pennsylvania that will be in the best interest of its citizens as patients. For this reason, the committee has dealt with the president's address and the

resolutions of the county medical societies in accordance with the following report that also coincides with the manner in which the matters were given consideration by the Reference Committee Hearings."

Resolutions Relating to Corrective Legislation

Mr. Speaker, the committee has considered Resolutions 75-S-7, 75-S-12, 75-S-16, 75-S-25, and 75-S-26 and recognizes their common interest in supporting the principles incorporated in House Bill 805.

Resolution 75-S-7

Subject: Support of HB 805

Introduced by: Howard L. Carbaugh, M.D., in behalf of the Lehigh County Medical Society

WHEREAS, Concerned physicians strive to deliver quality medical care to the consumer at a reasonable cost; and

WHEREAS, Medical malpractice costs have skyrocketed way ahead of other fixed costs forcing many physicians to reappraise their fees; and

WHEREAS, Medical malpractice costs have threatened to force established physicians out of practice; and

WHEREAS, High medical malpractice costs have kept new physicians out of Pennsylvania; and

WHEREAS, High medical malpractice costs for hospitals have raised the per diem bed costs higher than necessary; and

WHEREAS, Fear of suit has forced the physician to order unnecessary tests and x-rays; therefore be it

RESOLVED, We physicians of Lehigh County support in principle House Bill 805 now under consideration in the Judiciary Committee; and be it further

RESOLVED, We strongly urge its swift passage and immediate implementation in order to alleviate the current Malpractice Liability Insurance Crisis now present throughout our state.

Resolution 75-S-12

Subject: Support of HB 805

Introduced by: Joseph V. Caliguiri, M.D., secretary , in behalf of the Allegheny County Medical Society

Author: Robert E. Davis, M.D.

WHEREAS, No physician can be expected to care for patients without insurance protection in the present liability climate of this Commonwealth; and

WHEREAS, The escalating costs of such liability insurance must increase the costs of physicians' services; and

WHEREAS, The present costs of hospital care are, in part, due to a malpractice climate created by "trial law" rather than legislation; therefore be it

RESOLVED, That we strongly support the efforts of Pennsylvania Legislators to expedite the provision of medical care by implementing H.B. 805.

Resolution 75-S-16

Subject: Support of H.B. 805

Introduced by: Ulysses E. Watson, M.D., secretary, in behalf of the Montgomery County Medical Society

Author: Aureliano Rivas, M.D.

WHEREAS, Montgomery County Medical Society recognizes the whole nation to be in the midst of a grave medical crisis, produced by our present malpractice liability system, affecting directly every physician and health care provider in our country, and indirectly, every citizen in the United States; and

WHEREAS, Physicians entering practice are having difficulty obtaining adequate malpractice insurance; and

WHEREAS, All physicians are facing high premium increases this year, some specialists over 600%; and

WHEREAS, The Montgomery County Medical Society recognizes certain legislation has been introduced in the several states to solve this malpractice crisis, and that such legislation is also in the hands of the elected officials of the Assembly of the Commonwealth of Pennsylvania; and

WHEREAS, The Pennsylvania Medical Society has endorsed House Bill 805; therefore be it

RESOLVED, The Pennsylvania Medical Society continue to forcefully support Bill 805 or other legislation with similar provisions so as to effect the needed changes in the present malpractice liability system.

Resolution 75-S-25

Subject: Support of H.B. 805

Introduced by: Joseph V. Caliguiri, M.D., secretary, in behalf of Allegheny County Medical Society

Author: Michael P. Levis, M.D.

WHEREAS, The abrupt rise in premiums for malpractice insurance is discouraging young physicians from starting their practice in Pennsylvania; and

WHEREAS, This cost of liability insurance and the discouraging rise in unjustified claims is prompting older physicians to retire prematurely; and

WHEREAS, The retirement of older physicians and loss of younger physicians can only lead to a lessening of medical care available to the citizens of Pennsylvania; and

WHEREAS, The public information media of all kinds, including medical society publications, have stressed a "doctor strike" aspect to recent slowdowns of providing medical services exclusive of emergency problems; therefore be it

RESOLVED, That appropriate legislation be supported at the state level to protect the public from this aspect of runaway health care costs; and be it further

RESOLVED, That only legislation which includes the provisions of HB 805 can correct the problem as well as prevent an otherwise inevitable crisis in the provision of medical care; and be it further

RESOLVED, That every reasonable resource of the Pennsylvania Medical Society continue to be used to support the passage of HB 805 in an effort to obtain a fair restraint on medical liability verdicts and a better control of errant medical practitioners; and be it further

RESOLVED, That public relations efforts be directed away from the false label of a "doctor strike" to the true designation of HB 805 as a "Peoples Bill"; and be it further

RESOLVED, That a concerted and systematic attempt be made to enlist the general public, representatives of labor, industry, commercial insurers, parent-teacher and fraternal organizations to attend the hearings on HB 805 and HB 1367 and request support from their legislators for Representative William Shane's HB 805.

Resolution 75-S-26

Subject: Support of H.B. 805

Introduced by: Joseph V. Caliguiri, M.D., secretary, in behalf of Allegheny County Medical Society

Author: William A. Barrett, M.D.

WHEREAS, The astronomic increases in the premiums being charged to physicians for medical service liability insurance affect the practice of those physicians and help to determine the fees they charge; and

WHEREAS, The cost of medical liability insurance to physicians is relative only as another item of overhead expense eventually paid by patients, insuring programs and governmental agencies; and

WHEREAS, The public information media of all kinds, including medical society publications, have stressed a "doctor strike" aspect to recent slowdowns of providing medical services exclusive of emergency problems; and

WHEREAS, These attempts by physicians to prevent further increases in the cost of medical care by controlling the cost of insurance premiums to everyone; therefore be it

RESOLVED, That appropriate legislation be supported at the state level to protect the public from this aspect of runaway health care costs; and be it further

RESOLVED, That only legislation which includes the provisions of H.B. 805 can correct the problem as well as prevent an otherwise inevitable crisis in the provision of medical care; and be it further

RESOLVED, That every reasonable resource of the Pennsylvania Medical Society continue to be used to support the passage of H.B. 805 in an effort to obtain a fair restraint on medical liability verdicts and a better control of errant medical practitioners; and be it further

RESOLVED, That public relations efforts be directed away from the false label of a "doctor strike" to the true designation of H.B. 805 as a "Peoples Bill"; and be it further

RESOLVED, That a concerted and systematic attempt be made to enlist the general public, representatives of labor, industry, commercial insurers, parent-teacher and fraternal organizations to attend the hearings on HB 805 and HB 1367 and request support from their legislators for Representative William Shane's HB 805.

"Mr. Speaker, your Reference Committee recommends their approval, including the recruitment of support from the general public, labor, industry, insurance and fraternal organizations.

(Secretary's Note: The recommendation was amended by addition to provide that the Board of Trustees be urged to send materials to members detailing the methods by which they can influence patients and legislators, and that the Board also set up a specific day and date for a statewide mass demonstration to inform the public of the magnitude of the problem. The recommendation of the Reference Committee passed as amended.)

"Further your Reference Committee concurred with the intent of Resolution 75-S-3 by virtue of the fact that it provides for a medical review panel that it is an improvement over that described in House Bill 805.

Resolution 75-S-3

Subject: Medical Review Panel of the Patients Compensation Board

Introduced: Harriet Harry, M.D., secretary, in behalf of the Centre County Medical Society

Author: Harriet Harry, M.D.

WHEREAS, The Medical Review Panel of the Patients Compensation Board will sit in judgment of a physician and his acts performed in his practice of medicine; and

WHEREAS, Judgment of such acts can best be made by those versed in the practice of medicine; therefore be it

RESOLVED, That the voting members of the Panel should consist of three physicians and the judgment of the Panel should be reached by majority vote. One physician should be selected by the plaintiff, one should be selected by the defendant, and a third should be selected by the preceding two, if necessary, at random from those in practice in the jurisdiction. The Panel should have a practicing attorney as its non-voting chairman who will also serve as legal advisor to the Panel. The attorney-chairman shall be selected jointly by the physicians designated by the plaintiff and defendant or, if necessary, at random from those practicing law in the jurisdiction; and be it further

RESOLVED, That if either side wishes to carry the case to Court, the proceedings and decisions of the Panel are to be admissible as evidence.

"Mr. Speaker, Your Reference Committee recommends approval of Resolution 75-S-3.

"Your Reference Committee also considered the two-trial system as proposed in Resolution 75-S-19. It is not believed that the intent of the resolution will be accomplished by such a system, but that the intent will best be accomplished by the reform of the tort system as set forth in House Bill 805.

Resolution 75-S-19

Subject: Change in Method of Malpractice Insurance Suits

Introduced by: Harmon J. Machanic, M.D., in behalf of the Lycoming County Medical Society

Author: Harmon J. Machanic, M.D.

WHEREAS, The health, safety and welfare of Pennsylvania is being threatened by the limited availability and potential unavailability of malpractice insurance; and

WHEREAS, This limited availability and potential unavailability of malpractice insurance is caused by the ever-increasing number of law suits filed and the ever-increasing amount of judgments awarded; and

WHEREAS, 85 percent of the malpractice suits are actually due to maloccurrence rather than malpractice; and

WHEREAS, Monies are often awarded in malpractice suits by juries in suits which are actually maloccurrence suits out of sympathy for the patients; and

WHEREAS, The interest of justice is best served when the determination of facts and the awarding of monies are separated; therefore be it

RESOLVED, That the Lycoming County Medical Society urge the Pennsylvania Medical Society, on behalf of the public good of our community and Commonwealth, to seek as one of its points for presentation to the Legislature to be written into the needed new malpractice law that in the event of a law suit following arbitration, that the present all inclusive trial be eliminated and the two trial system substituted, which would include a preliminary trial to determine whether in fact malpractice or maloccurrence occurred, and if malpractice was determined to have occurred, a second trial or hearing then be set to determine damages to the patient.

"Mr. Speaker, your Reference Committee recommends rejection of Resolution 75-S-19.

(Secretary's Note: Following discussion and a vote on the floor of the House, it was determined to refer Resolution 75-S-19 to the ad hoc committee on Malpractice.)

Resolutions Relating to Insurance Premium Rollbacks

"Your Reference Committee has carefully considered the many resolutions that recommend a premium rollback and is sensitive to the great sense of urgency with which this subject is regarded by the House of Delegates. We recognize the realities of the difficult situation represented by premium rollbacks and believe that they should most logically follow corrective legislation. The committee recognizes, however, that on April 25, 1975, the Pennsylvania Medical Society entered into an agreement with the Argonaut Insurance Company reserving its right '. . . without prejudice to assert in the future that the rate has been demonstrated to be excessive at that date.'

"Your committee recommends that the Board of Trustees be directed to examine the justification of the rate structure currently in effect and to report back to this House of Delegates in October 1975 on the appropriateness of such rates and on remedial action to reduce such rates if appropriate.

Resolution 75-S-2

Subject: Injunction for Insurance Premium Roll Back

Introduced by: John D. Lane, M.D., delegate, in behalf of the Bucks County Medical Society

WHEREAS, The health, safety and welfare of Pennsylvania is endangered by the limited availability and potential unavailability of malpractice insurance; and

WHEREAS, Health costs will continue to be driven upward by soaring insurance rates and an overload of defensive medical procedures by both doctors and hospitals; and

WHEREAS, Our communities are and will be in a public health crisis because of lack of essential medical services (especially orthopedists, neurosurgeons and anesthesiologists); and

WHEREAS, This crisis was allowed to develop because the public good was not protected by either the insurance companies, State Insurance Department, or the legislators; and

WHEREAS, The State Legislature may require more time to resolve this issue in a fair manner; therefore be it

RESOLVED, That the Bucks County Medical Society urge the Pennsylvania Medical Society, on behalf of the public good of our community and Commonwealth, seek an injunction in Federal Court on the Argonaut Insurance Company to roll back premiums as they existed on an appropriate date prior to April 1, 1975.

Resolution 75-S-5

Subject: Premium Roll Back

Introduced by: Paul M. Lin, M.D.

Author: Paul M. Lin, M.D., and Herbert C. Dodge, M.D.

WHEREAS, The inordinately massive rate increase of professional liability insurance premiums granted to Argonaut Insurance Company of Menlo Park, California, has cost the people of Pennsylvania undue hardship in obtaining adequate and affordable medical care; and

WHEREAS, Said rate increase was not based on proof of financial need by said Insurance Company; therefore be it

RESOLVED, That the Pennsylvania Medical Society bring legal action to enjoin said Insurance Company to roll back its premiums to the March 31, 1975 level.

Resolution 75-S-8

Subject: Rollback of Malpractice Premiums

Introduced by: Irvin Williams, M.D.

Author: J. Preston Hoyle, M.D.

WHEREAS, Health care costs are driven up by soaring insurance rates; and

WHEREAS, Increased insurance costs are being passed on to patients in the form of higher charges for health care services and facilities; and

WHEREAS, Many health care providers on the verge of retirement but still very productive, cannot afford insurance and are exposing themselves and consumers to unreasonable risk in the event of loss; and

WHEREAS, Some health care providers have been forced to curtail the practice of all or a part of their professions because of the unavailability and high cost of malpractice insurance; and

WHEREAS, The supply of new physicians for the Commonwealth is seriously threatened; and

WHEREAS, The difficulty and high cost of obtaining insurance for health care providers discourages young physicians from entering into the practice of medicine in the Commonwealth of Pennsylvania, resulting in the loss of physicians to other states; and

WHEREAS, Any meaningful legislation, even if passed immediately, will only provide for long term relief to the physicians and patients; and

WHEREAS, There is nothing in sight to give physicians and their patients relief from ever increasing malpractice premiums; therefore be it

RESOLVED, That at the moment that we have meaningful legislation passed by the Legislature and enacted into law, that we have an immediate rollback of malpractice insurance premiums to those premiums that were in effect as of January 1, 1975.

Resolution 75-S-15

Subject: "Freeze" on Insurance Premiums

Introduced by: Ulysses E. Watson, M.D., secretary, in behalf of the Montgomery County Medical Society

Author: Aureliano Rivas, M.D.

WHEREAS, Montgomery County Medical Society recognizes legislation has been introduced to solve the malpractice crisis, and such legislation is in the hands of elected officials of the Assembly of the Commonwealth of Pennsylvania; and

WHEREAS, Montgomery County Medical Society and Pennsylvania Medical Society have endorsed House Bill 805; and

WHEREAS, Montgomery County Medical Society recognizes the legislative process to be complex, lengthy, and subject to many delays of various and unforeseen causes; and

WHEREAS, Montgomery County Medical Society recognizes, at best, if any legislative bill is enacted, the effective date will be after 1 January, 1976; therefore be it

RESOLVED, The Pennsylvania Medical Society shall request the appropriate Commonwealth authorities to mandate all malpractice insurance rates be frozen as of 1 March 1975, until appropriate legislation becomes effective and based on this legislation, new rates are established by the insurance companies and the Insurance Commissioner of the Commonwealth of Pennsylvania.

Resolution 75-S-17

Subject: Hearing Before State Insurance Department

Introduced by: John D. Lane, M.D., delegate, Bucks County Medical Society

Author: John D. Lane, M.D.

WHEREAS, The health, safety and welfare of Pennsylvania is endangered by the limited availability and potential unavailability of malpractice insurance; and

WHEREAS, Health costs will continue to be driven upward by soaring insurance rates and an overload of defensive medical procedures by both doctors and hospitals; and

WHEREAS, Our communities are and will be in a public health crisis because of lack of essential medical services (especially orthopedists, neurosurgeons and anesthesiologists); and

WHEREAS, The State Legislature may require more time to resolve this issue in a fair manner; therefore be it

RESOLVED, That the Pennsylvania Medical Society file a complaint with the Pennsylvania Insurance Department and request a hearing with regard to the justification of granting Argonaut Insurance Company a 206 percent rate increase in malpractice premiums.

"Mr. Speaker, in view of the aforementioned recommendation, your Reference Committee recommends rejection of Resolutions 75-S-2, 75-S-5, 75-S-8, 75-S-15, and 75-S-17."

(Secretary's Note: Following introduction of the Reference Committee's recommendation, a motion was made, seconded and passed that all references to reporting back to the House of Delegates in October 1975 be changed to reporting back to this House of Delegates not later than October 1975, thus including the possibility of reports back to a reconvening of this special session before the next regular session in October 1975.)

It was moved, seconded, and passed that the above resolutions be referred to the Board of Trustees without rejection, or action of any kind at this time, and further that the Board of Trustees look into the feasibility of a court action for full disclosure of information needed to review rate increases, and report to the House of Delegates not later than October.

It was the understanding of the Reference Committee that the Durkin Report was obtained and funded as an informational report for the Commission on Professional Liability Insurance of the Pennsylvania Medical Society.

Resolution 75-S-18

Subject: Release of Durkin Report

Introduced by: John D. Lane, M.D., delegate, Bucks County Medical Society

Author: John D. Lane, M.D.

WHEREAS, The health, safety and welfare of Pennsylvania is endangered by the limited availability and potential unavailability of malpractice insurance; and

WHEREAS, Health costs will continue to be driven upward by soaring insurance rates and an overload of defen-

sive medical procedures by both doctors and hospitals; and

WHEREAS, Our communities are and will be in a public health crisis because of lack of essential medical services (especially orthopedists, neurosurgeons and anesthesiologists); and

WHEREAS, This crisis was allowed to develop because the public good was not protected by either the insurance companies, State Insurance Department, or the legislators; and

WHEREAS, The Durkin Report may point out that the Argonaut Insurance Company was not entitled to such a large increase in premiums: and

WHEREAS, The Durkin Report was funded by the Pennsylvania Medical Society; therefore be it

RESOLVED, That the Pennsylvania Medical Society release the Durkin Report to any Society member upon request.

"Mr. Speaker, your Reference Committee recommends rejection of Resolution 75-S-18 but recommends that the Durkin Report continue to be made available at the State Medical Society Headquarters Building for the personal perusal of any interested PMS member.

"The Reference Committee has given consideration to Resolution 75-S-28 and feels that information obtained by such a poll may be of value in determining future medical society policy.

Resolution 75-S-28

Subject: Poll of Argonaut Insured Physicians

Introduced by: Herbert C. Dodge, M.D., in behalf of the Philadelphia County Medical Society

Author: Herbert C. Dodge, M.D.

WHEREAS, The Pennsylvania Medical Society, acting in good faith, has heretofore assumed that those physicians insured by Argonaut are against any action by the Pennsylvania Medical Society to roll back premium increases because of the risk that Argonaut may leave the State of Pennsylvania; and

WHEREAS, Such an assumption may not reflect the true feelings of those physicians actually insured by Argonaut; therefore be it

RESOLVED, That the Pennsylvania Medical Society shall poll those physicians insured by Argonaut forthwith to ascertain their true feeling.

(Secretary's note: Some suggested questions are: (1) Are you insured by Argonaut? Yes____ No____ (2) If the answer is yes, are you willing to have the Pennsylvania Medical Society bring legal action against Argonaut to effect a rollback of premiums, even if such action entails the risk that Argonaut may leave the State of Pennsylvania? Yes____ No ____)

"Mr. Speaker, your Reference Committee recommends approval of Resolution 75-S-28.

"Your Reference Committee has considered Resolution 75-S-30 and is of the understanding that material used by the Insurance Commissioner for rate promulgation is available to the press and the general public.

Resolution 75-S-30

Subject: Malpractice Crisis

Introduced by: Edgar W. Kline, M.D., delegate, Montgomery County Medical Society

Author: Edgar W. Kline, M.D.

WHEREAS, Montgomery County Medical Society recognizes the present grave medical crisis, produced by our present malpractice liability system, has given rise to exorbitant professional liability insurance rates; and

WHEREAS, It has become apparent since April 1, 1971 by a combination of increased rate promulgations and the ability of the insurance providers to be allowed to adopt new limit factors, the actual increase to some physicians for professional liability insurance has amounted to a 476 percent increase; and therefore be it

RESOLVED, We urge the Pennsylvania Medical Society to petition the Insurance Commissioner of Pennsylvania to release to the public, and notably to the press, the relevant information available to the Commissioner's office to justify these increases.

"Mr. Speaker, your Reference Committee recommends approval of Resolution 75-S-30. Resolutions Relating to Methods for the Accomplishment of Desired Legislation.

"Your Reference committee has given consideration to the eight resolutions and the recommendations from the address of the president that relate to methods at the disposal of physicians for emphasizing their concern for rising malpractice premium rates.

Recommendations 3 and 4 from the President's Address:

'That physicians use a written agreement signed prior to acceptance of patients for settlement of patient dissatisfaction through binding arbitration.

'That the PMS use its Medical Defense Fund to cover the legal costs of any meritorious "abuse of process" case on behalf of physicians who have successfully defended against a malpractice charge.'

"Mr. Speaker, your Reference Committee recommends that recommendations three and four from the president be approved, namely, that physicians use a written agreement signed prior to acceptance of patients for settlement of patient dissatisfaction through binding arbitration, the mechanism and form (see appended sample) to be implemented by the Board of Trustees.

"Mr. Speaker, your Reference Committee recommends that the Pennsylvania Medical Society use Medical Defense Funds to cover legal costs of prosecution of meritorious 'abuse of process' cases on behalf of physicians who have successfully defended against a malpractice charge and no assessment be conducted at this time.

(Secretary's Note: Following lengthy discussion the following amendment to the above recommendation was made:

That the Board of Trustees be authorized to make a mandatory assessment of each member in an appropriate amount, the purpose being for general use in aiding in the malpractice liability problem.)

"The Committee has similarly given consideration to recommendations one and two from the address of the president:

1. That until such time as significant legislation is enacted:

A. That physicians will continue to provide medical care but will withdraw as participants of all insurance programs (Blue Shield, Medicare, Medicaid, commercial insurance plans for corporate plans), will accept no assignments and will execute no payment forms until that time.

B. No medical reports will be rendered by physicians to attorneys in cases relating to claims for medical disability.

C. Physicians will refuse to testify on an adversary basis in cases claiming medical disability.

2. That this Society declare it unethical for a physician to accept a fee for medical testimony and that the PMS establish a system through which medical testimony will be furnished as a "friend of the court" but not on an adversary basis.'

"Mr. Speaker, your Reference Committee is concerned over certain legal and practical implications of recommendation one, and it recommends that this matter be referred back to the Board of Trustees for further study and report to this House of Delegates in October 1975.

(Secretary's Note: At this time it was properly moved, seconded, and passed that the House go into closed session. Invited guests and representatives of the media left at this time. Following lengthy discussion on the question, the closed session came to an end and the House went back to its regular open session. A vote was taken on the recommendation of the Reference Committee and it passed.)

"Mr. Speaker, your Reference Committee further recommends that the ethical matters referred to in recommendation number two from the address of the president be referred to the Judicial Council of the Pennsylvania Medical Society:

(Secretary's Note: Discussion followed this recommendation concerning whether the House could declare it unethical for a physician to accept a fee for medical testimony. It was the feeling of the House that this should be referred to the Judicial Council for adjudication.)

"Your Reference Committee has given specific consideration to the resolutions that relate to restriction of medical services, as presented to the House of Delegates. Testimony suggests to us that physicians find the concept of restricting services contrary to the traditional principles of medical ethics. However, we recognize that its use may be inevitable in accomplishing the long range preservation of good medical practice. In addition, we recognize that legislation by the State government is currently being developed, and may, by virtue of corrective amendments, resolve the problem.

Resolution 75-S-1

Subject: Statewide Restriction of Medical Services

Introduced by: John D. Lane, M.D., delegate, in behalf of the Bucks County Medical Society

Author: John D. Lane, M.D.

WHEREAS, The health, safety and welfare of Pennsylvania is endangered by the limited availability and potential unavailability of medical malpractice insurance; and

WHEREAS, Health costs will continue to be driven upwards by soaring insurance rates and an overload of defensive medical procedures by both doctors and hospitals; and

WHEREAS, This crisis was allowed to develop because of inadequate malpractice legislation; therefore be it

RESOLVED, That if there is not adequate legislative relief in the malpractice crisis, we urge a statewide restriction of medical services until the legislature acts responsibly.

Resolution 75-S-9

Subject: Malpractice

Introduced by: Edward A. Lottick, M.D., secretary, Luzerne County Medical Society

Author: Peter J. Corey, M.D.

WHEREAS, The issue of malpractice has become a pressing problem, and there is a need for immediate solution; therefore be it

RESOLVED, That if H.B. 805 or its equivalent is not law, i.e., passed by the House, passed by the Senate, and ratified by the Governor, within sixty (60) days from July 3, 1975, the Pennsylvania Medical Society should start a statewide restriction of medical services.

Resolution 75-S-23

Subject: Deferral of Medical Treatment

Introduced by: Edward J. Resnick, M.D., secretary, in behalf of the Philadelphia County Medical Society

WHEREAS, The present malpractice crisis increasingly impairs adequate delivery of health care to the citizens of the Commonwealth of Pennsylvania; and

WHEREAS, The present medical crisis prevents a proper atmosphere for the effective practice of medicine in the State of Pennsylvania; therefore be it

RESOLVED, That if satisfactory legislation is not enacted or a rollback made to March 1, 1975 malpractice premiums, the Pennsylvania Medical Society will support

a statewide action to consist of deferring medical treatment to new non-emergency patients; and be it further

RESOLVED, Scrupulous care will be taken so that emergency patients or patients under treatment will continue to receive medical care.

Resolution 75-S-27

Subject: Restriction of Non-Essential Services

Introduced by: Robert L. Lasher, M.D., in behalf of the Erie County Medical Society

Author: Robert L. Lasher, M.D.

WHEREAS, Health care costs are driven up by soaring insurance rates; and

WHEREAS, The cost of medical liability insurance premiums has reached proportions restricting Pennsylvania physicians from practice thereby endangering medical care in Pennsylvania; and

WHEREAS, The number of medical liability claims are rising in dangerous proportions; and

WHEREAS, No appropriate relief has been provided to the physicians in Pennsylvania from medical liability expense; and

WHEREAS, Many of the services performed by physicians are necessary but not essential to patient care; and

WHEREAS, The withholding of these services will bring attention of our problem to the public and the Legislature; therefore be it

RESOLVED, That immediately the physicians in Pennsylvania restrict nonessential services now being rendered. These restrictions would include refusal to do examinations, evaluations and recommendations on patients for insurance companies, the legal profession, the Bureau of Vocational Rehabilitation, Bureau of Transportation, Department of Public Welfare, and such services which do not involve patient care, to any other State related agencies or third party payors. Such restrictions to continue until meaningful legislation has been passed. In the event no such legislation is forthcoming in the next 60 days, restriction of services be extended to include nonemergency care of patients.

"Mr. Speaker, your Reference Committee recommends rejection of Resolutions 75-S-1, 75-S-9, 75-S-23, and 75-S-27 by virtue of the fact that they mandate and pinpoint dates for the implementation of job actions.

(Secretary's Note: A substitute resolution was introduced, moved, seconded and passed, reading: "That the Pennsylvania Medical Society advise the Governor, the State Legislators, and the people of Pennsylvania who are our patients, the type of malpractice legislation now being considered by the Legislature will not correct the malpractice problem and is totally unacceptable to Pennsylvania physicians. Failure of the Legislature to recognize this fact and to enact legislation embodying the concepts of H.B. 805 will be countered by future stern measures of increasing magnitude.")

"In view of the fact that this special session of the House of Delegates will be held in recess rather than adjourn, it is the recommendation of your Reference Committee that we approve Resolution 75-S-21, with the amendment as follows:

Resolution 75-S-21

Subject: Cumberland County Support of Necessary Slowdowns

Introduced by: H. Robert Davis, M.D., secretary, in behalf of Cumberland County Medical Society

WHEREAS, The Cumberland County Medical Society is aware of the especially severe burden the increased rates impose on our beleaguered colleagues in insurance District 1; and

WHEREAS, No reasonable alternative was available to the physicians but to conduct a slowdown; and

WHEREAS, The continuation of the malpractice insurance crisis may make further slowdowns necessary; therefore be it

RESOLVED, That if after deliberation and consideration of all possible alternatives, no alternatives to slowdowns are apparent, the Cumberland County Medical Society urges the Pennsylvania Medical Society to support such slowdowns.

Amended Resolved:

Resolved, That if adequate corrective legislation is not forthcoming as determined by the Board of Trustees, that this special session of the House of Delegates be reconvened to give serious consideration to the matter of a statewide slowdown at the appropriate time.

"Mr. Speaker, your Reference Committee recommends the adoption of the amended resolution.

"Your Reference Committee has given consideration to Resolution 75-S-14 and recommends the exploration of all legal means to resolve our problem.

Resolution 75-S-14

Subject: The Physician's Commitment to Patients and the Physician's Practice Rights

Introduced by: George Ashman, M.D., in behalf of the Cambria County Medical Society

Author: George Ashman, M.D.

RESOLVED, That the primary commitment of the Cambria County Medical Society and its physician members is to the essential medical needs of the people of this community; and be it further

RESOLVED, That the Cambria County Medical Society recognizes that it is the inalienable right of physicians to decide for themselves the circumstances under which they can or cannot continue to practice his or her profession; and be it further

RESOLVED, That the Cambria County Medical Society recognizes that physicians are entitled to use all available legal means, without jeopardizing the medical care of their patients, to protest when intolerable and unwar-

ranted burdens are placed upon their patients, the society or its members; and be it further

RESOLVED, That the Pennsylvania Medical Society consider adoption of this policy statement at the Special Session of the House of Delegates; and be it further

RESOLVED, That the Pennsylvania Medical Society continue to study the effects of changing socioeconomic conditions on the ability of physicians to practice medicine.

"Mr. Speaker, your Reference Committee recommends the adoption of Resolution 75-S-14.

Resolution 75-S-11

Subject: Alternatives to Slowdowns

Introduced by: Joseph V. Caliguiri, M.D., secretary, in behalf of Allegheny County Medical Society

Author: Michael P. Levis, M.D.

WHEREAS, The medical profession has a long and distinguished record of service to mankind; and

WHEREAS, The role of the physician is to provide service in time of need; therefore be it

RESOLVED, That this House of Delegates affirm that the concept of withholding of service as a socioeconomic alternative is a reaction not in the best interest of patients; and be it further

RESOLVED, That if no valid answer to the liability crisis is obtained by the next general session of the House of Delegates, October, 1975, the Pennsylvania Medical Society shall consider other sanctions to support our position and the public interest with regard to the professional liability crisis.

"Mr. Speaker, we have considered the contents of Resolution 75-S-11 and by virtue of its recommendation that all sanctions be considered, recommend its adoption.

"In the event that a slowdown may ultimately be necessary, the Pennsylvania Medical Society, through the county medical societies, should begin now with the development of a plan for emergency care.

Resolution 75-S-10

Subject: PMS Contingency Plan for Emergency Medical Care

Introduced by: James F. Welsh, M.D., in behalf of the Berks County Medical Society

Author: James F. Welsh, M.D.

WHEREAS, The current crisis in malpractice insurance may force many Pennsylvania physicians to curtail or cease the practice of medicine until the crisis is resolved; and

WHEREAS, The case of sick people is always the primary duty, concern and responsibility of physicians; therefore be it

RESOLVED, That a plan for the emergency care of the people of Pennsylvania be drawn up by the Board of Trustees of the Pennsylvania Medical Society for implementation in the event of forced curtailment of medical services.

"Mr. Speaker, your Reference Committee has studied Resolution 75-S-10 and recommends its adoption.

Miscellaneous Resolutions

"Your Reference Committee has given consideration to the seven miscellaneous resolutions. The Committee is sympathetic with the inevitable need to practice defensive medicine as one way to avoid malpractice action. However, we believe a professional association should not promote bad and extravagant medical practice.

Resolution 75-S-4

Subject: Endorsement of Defensive Medicine

Introduced by: John P. Whitely, M.D., secretary in behalf of the York County Medical Society

Author: John P. Whitely, M.D.

WHEREAS, The malpractice crisis is in large part due to over-zealous attorneys, liberalization of legal doctrines, and an increasingly litigious public; and

WHEREAS, Physicians are faced with having to look upon patients as potential adversaries; and

WHEREAS, Physicians are being deprived of insurance coverage at reasonable rates; and

WHEREAS, Physicians are threatened with nuisance, spurious and nonmeritorious claims; therefore be it

RESOLVED, That the Pennsylvania Medical Society urge all members to implement whatever defensive medicine measures are required to withstand future claims of negligence.

Resolution 75-S-29

Subject: Extreme Defensive Medicine

Introduced by: Irving Williams, III, M.D., Union County Medical Society

Author: Irving Williams, III, M.D.

WHEREAS, All attempts to alleviate the crisis caused by the increase in malpractice insurance premiums have been ignored by the state legislature; and

WHEREAS, The physicians in the Commonwealth of Pennsylvania must take unilateral action to protect themselves from the financial and psychological burdens of litigation, now therefore be it

RESOLVED, That the following precautions be initiated by the members of the Pennsylvania Medical Society starting July 7, 1975:

1. Extreme defensive medicine, that is all those steps which may be taken to preclude the possibility of even a 0.001 percent chance of poor results:
   a. all laboratory and x-ray studies
   b. all consultations before undertaking medical or surgical therapy

c. all hospitalizations for treatment or close observation
d. frequent visits to the doctor's office to evaluate progress
e. complete examinations and work-ups for minor as well as major complaints. The extra time involved to be paid by insurance and patients.
f. all possible braces, supports, physical therapy, occupational therapy, drugs, special nurses, health care aids, etc., to cure or prevent disease

2. Do not sign papers or give medical opinions where full legal implications are not fully understood:

a. Death certificates
b. Birth certificates
c. Wasserman Tests for Marriage
d. Driver's License unless job depends on it
e. Exams for Life Insurance
f. Shot records for school and passports
g. Permission to play school sports or take physical education
h. Utilization Committee Reports
i. Peer Review
j. Accident Reports for Police
k. Professional Witness at Trials
l. Withholding of Medical Forms till 60 day period is up

"Mr. Speaker, your Reference Committee recommends rejection of Resolutions 75-S-4 and 75-S-29. However, in conjunction with the study that the Board of Trustees will direct to recommendation number one of the address of the president, we suggest that a similar study be directed to the subject matter of item number two of the resolved of Resolution 75-S-29.

(Secretary's Note: The Speaker divided this question. A vote was first taken upon the rejection of Resolution 75-S-4 and item number one of Resolution 75-S-29. The recommendation of the Reference Committee was upheld and these matters were rejected. A vote was then taken on item number two of the resolved of Resolution 75-S-29, and it was determined to conduct a study in a similar manner to item number one of the address of the president, as recommended by the Reference Committee.)

Resolution 75-S-22

Subject: PMS Joining Member-Defendants in Counterclaim for Abuse of Process

Introduced by: Samuel S. Faris, M.D., delegate, Montgomery County Medical Society

Author: Samuel S. Faris, M.D.

WHEREAS, An effort by a group is often more effective than by an individual; and

WHEREAS, A group, the Pennsylvania Medical Society, exists among Pennsylvania physicians; and

WHEREAS, Pennsylvania physicians are forced to accept suits-at-law stipulating so-called malpractice in a supine, toothless and defenseless fashion; therefore be it

RESOLVED, That the Pennsylvania Medical Society join with certain member-defendants (in malpractice suits deemed by Pennsylvania Medical Society to have little merit) to counterclaim for abuse of process.

"Mr. Speaker, your Reference Committee recommends approval of Resolution 75-S-22 by virtue of the fact that it conforms with recommendation number four of the address of the president which provides for the pursuit of counterclaims as they relate to the abuse of process, and we strongly recommend the implementation of this action in a meritorious case.

Resolution 75-S-6

Subject: Board of Trustees and Councilors and High Risk Specialists

Introduced by: Paul M. Lin, M.D.

Author: Paul M. Lin, M.D., and Herbert C. Dodge, M.D.

WHEREAS, The Pennsylvania Medical Society Board of Trustees and Councilors has been making day to day policy decisions in reference to the Professional Liability Insurance Crisis on behalf of the high risk specialists, and speaking in the name of said specialists without adequate representation and input by the high risk specialists; therefore be it

RESOLVED, That representatives from Anesthesiologists, Orthopedic Surgeons, and Neurosurgeons, sit in on all discussion and decision making of the Board of Trustees and Councilors of the Pennsylvania Medical Society until the Professional Liability Insurance Crisis is resolved.

"Mr. Speaker, in accordance with Dr. Crane's address and the desire of its sponsor to withdraw Resolution 75-S-6, we recommend its rejection.

"Your Reference Committee was sympathetic with the intent of Resolution 75-S-13 but believes that the resolved calling for an assessment be considered after the Board of Trustees has given consideration to the present budgetary allocations for publicity.

Resolution 75-S-13

Subject: Passage of H.B. 805

Introduced by: David A. Smith, M.D., secretary, in behalf of the Dauphin County Medical Society

Author: David A. Smith, M.D.

RESOLVED, That organized medicine pursue all forms of publicity, including the press, radio, and TV to state our case on the malpractice insurance problem in an effort to secure passage of HB 805; and be it further

RESOLVED, That the Pennsylvania Medical Society make an effort to enlist the support of labor for our position; and be it further

RESOLVED, That the Pennsylvania Medical Society consider placing an assessment on each member to finance the cost of the program, if necessary.

"Mr. Speaker, your Reference Committee recommends approval of Resolution 75-S-13.

"Your Reference Committee has studied Resolution 75-S-20 and feels that there are many negative risks associated with billing surcharges for malpractice insurance.

Resolution 75-S-20

Subject: Surcharge On All Bills for Service Rendered

Introduced by: Harmon J. Machanic, M.D., in behalf of the Lycoming County Medical Society

Author: Harmon J. Machanic, M.D.

WHEREAS, The malpractice crisis is due in large part to nuisance and non-meritorious claims; and

WHEREAS, Physicians are being deprived of insurance coverage at reasonable rates; and

WHEREAS, Because with excessive, massive rate increases of professional liability insurance premiums granted to some malpractice insurance carriers in the recent past; and

WHEREAS, Medical malpractice costs have skyrocketed far ahead of other fixed costs; and

WHEREAS, Increased insurance costs must be passed on to patients in the form of higher charges; and

WHEREAS, The public and our patients are not completely and fully aware of either the problem or the costs; therefore be it

RESOLVED, That the physicians of Pennsylvania will on all bills and charges submitted for services rendered, compute and add a surcharge on all bills rendered to cover the increased costs of professional liability insurance; and be it further

RESOLVED, That the Pennsylvania Medical Society urge that the Insurance Commissioner of the Commonwealth of Pennsylvania instruct the insurance companies within the Commonwealth of Pennsylvania to pay the malpractice surcharge at the time that he grants an increase in professional liability insurance rates.

"Mr. Speaker, your Reference Committee recommends rejection of Resolution 75-S-20 with the recommendation that individual physicians use their best judgment regarding this practice.

"Your Reference Committee has studied Resolution 75-S-24, which calls for establishment of a Society formed and administered insurance company.

Resolution 75-S-24

Subject: Malpractice Insurance Corporation Established and Administered by Pennsylvania Medical Society

Introduced by: William J. Pherson, M.D., delegate, Butler County Medical Society

Author: William J. Pherson, M.D.

WHEREAS, The exorbitant premiums of certain insurers and threat of cancellation (if an insurance pool is formed by legislation) by another insurer of malpractice in the State of Pennsylvania; and

WHEREAS, This Special Session may consider formation of a Malpractice Insurance Corporation established and administered by, and, or under the auspices of the Pennsylvania Medical Society; therefore be it

RESOLVED, That if this proposal receives an affirmative vote from the delegates, it be referred to a special committee for detailed formulation as a contingency or optimal solution of the present insurance problem.

"Mr. Speaker, your Reference Committee recommends approval of Resolution 75-S-24 in view of the fact that it conforms with recommendation number five from the address of the president."

Announcements

The Speaker expressed the gratitude of the House to the Reference Committee for the lengthy and late hours it put in considering the items before it.

William Y. Rial, M.D., Delaware County, was recognized and spoke in appreciation of the way the speaker and vice speaker presided over the meeting. The House expressed its appreciation by applause.

The Chair recognized Dr. Samuel S. Faris, Montgomery County. Dr. Faris introduced a resolution in honor of the Society's president, Dr. A. Reynolds Crane:

Resolved, That the House of Delegates, in the name of all PMS, express its admiration, love, and appreciation to our president, A. Reynolds Crane, M.D.

The Resolution was adopted by acclamation.

Dr. Crane then rose to say a few words. He reviewed recently introduced Senate Bill 907, introduced by Senator Henry Hager. He reviewed the points of this bill and described it as the best yet, containing many of H.B. 805 principles, being much better than H.B. 1367, though not as good as H.B. 805. He reviewed briefly the provisions of S.B. 907.

Recess

Dr. Lovette announced that the chair was ready to receive a motion to recess. He pointed out the benefits of this action, rather than the action of adjourning the House, since the House could again meet on comparatively short notice, and so that other interested parties would know that the Pennsylvania Medical Society had not ended its concern for the malpractice insurance crisis with this meeting today. The House was recessed at 1:25 p.m.

Respectfully submitted,
John B. Lovette, M.D., Speaker
D. Ernest Witt, M.D., Vice Speaker
G. Winfield Yarnall, M.D., Secretary
John C. Rogalski, Assistant Secretary

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November 1975

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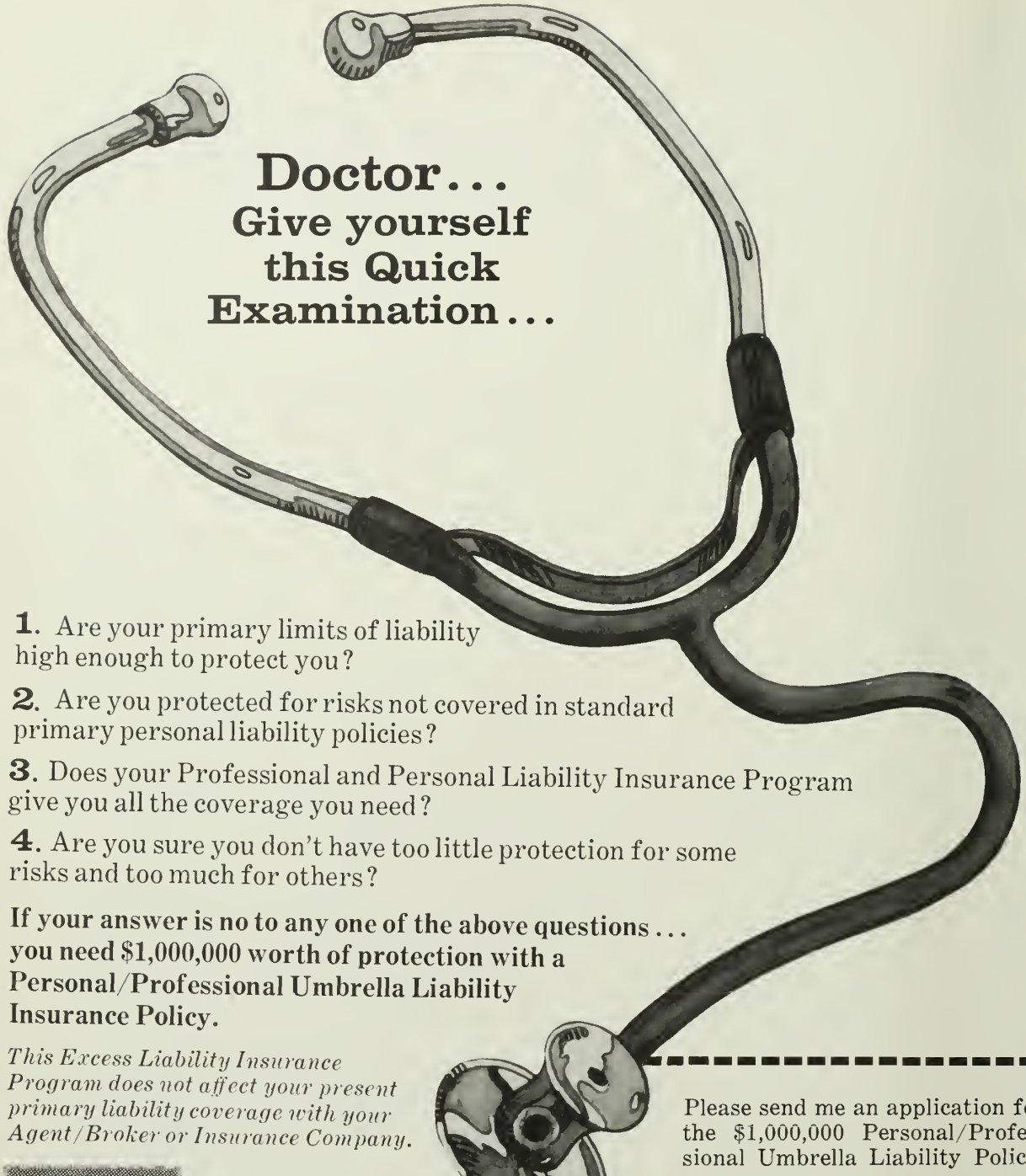

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Cover design by Jack Schmidt

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PENNSYLVANIA MEDICINE, established in 1897, is published monthly as the official publication of the Pennsylvania Medical Society. All original papers and correspondence should be directed to the Managing Editor. Subscription requests and changes of address should be sent to PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043. A subscription is $5.00 per year. Single issues are 50 cents. Second class postage is paid at Lemoyne, Pennsylvania 17043.

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New leadership named by House of Delegates

John V. Blady, M.D., Philadelphia surgeon, was elected vice president of the Pennsylvania Medical Society by the House of Delegates at its October meeting at the Host Farm Motel, Lancaster. David S. Masland, M.D., Carlisle internist, was installed as president, and William J. Kelly, M.D., Pittsburgh internist, automatically moved from the vice presidency to the presidency elect.

Dr. Blady, clinical professor of surgery at Temple University School of Medicine and director of the tumor clinic at Temple University Hospital, will succeed to the Society's presidency in two years. He has been active as a medical association leader for many years and served as president of the Philadelphia County Medical Society in 1967.

DRS. MASLAND, KELLY, AND BLADY

Two new trustees were elected during the 1975 Annual Session. Richard L. Huber, M.D., of Scranton, was chosen to represent the Third Councilor District, replacing Ralph K. Shields, M.D., of Bethlehem; and Carol N. Maurer, M.D., of Oil City, was named trustee of the Ninth Councilor District, replacing Cyrus B. Slease, M.D. Dr. Maurer becomes the first woman to serve on the Society's Board of Trustees. She is a psychiatrist, and has served as a member of the Society's House of Delegates. Dr. Huber, a family physician, has been a member of the State Society's House of Delegates, a member of the Council on Professional Relations and Services, and is an alternate delegate to the AMA House of Delegates.

Delegates re-elected G. Winfield Yarnall, M.D., secretary; John B. Lovette, M.D., speaker of the House of Delegates; and D. Ernest Witt, M.D., vice speaker.

Also elected for terms beginning in 1976 were these delegates to the AMA House of Delegates; Paul S. Friedman, M.D.; Philadelphia; John B. Lovette, M.D., Johnstown; Matthew Marshall, Jr., M.D., Pittsburgh; Malcolm W. Miller, M.D., Philadelphia; and Robert N. Moyers, M.D., Meadville. Alternate delegates for terms beginning in 1976 are: Lawrence D. Ellis, M.D., Pittsburgh; Henry H. Fetterman, M.D., Allentown; Wayne W. Helmick, M.D., Rochester; John H. Helwig, Jr., M.D., Philadelphia; and David J. Keck, M.D., Fairview.

Russell B. Roth, M.D., Erie, and George E. Farrar, M.D., New Hope, were re-elected to the Society's Judicial Council. Also re-elected to the Committee to Nominate Delegates and Alternates to the AMA were Dr. Blady and Charles K. Zug, III, M.D., Bethlehem.

Delegates also elected district censors including: James Allison, M.D., of Gettysburg; William D. Stewart, M.D., of Allison Park; Arthur R. Wilson, M.D., of Dayton; Herman Bush, M.D., of Beaver; G.L. Rinard, M.D., of Bedford; Brian A. Wummer, M.D., of Womelsdorf;

Also; John W. Hurst, M.D., of Altoona; Stanley F. Peters, M.D., of Plumsteadville; Robert C. McCorey, M.D., of Butler; Warren F. White, M.D., of Johnstown; H. Richard Ishler, M.D., of State College; Grant W. Bamberger, M.D., of Honey Brook;

Also; Theodore R. Koenig, M.D., of Knox; Fred Pease, M.D., of Clearfield; George J. Treires, M.D., of Lock Haven; James F. Youngkin, M.D., of Berwick; David D. Kirkpatrick, Jr., M.D., of Meadville;

Also; Hans S. Roe, M.D., of Carlisle; Robert P. Dutlinger, M.D., of Harrisburg; Richard W. Garlichs, M.D., of Havertown; Robert J. Dickinson, M.D., of Ridgway; Robert L. Loeb, M.D., of Erie; Veronica Binns, M.D., of Brownsville;

Also; Albert W. Freeman, M.D., of Shippensburg; David L. Avner, M.D., of Greensboro; Thomas R. Mainzer, M.D., of Huntingdon; Stephen J. Takach, M.D., of Indiana; Nicholas F. Lorenzo, M.D., of Brockway; Norman S. Berger, M.D., of Scranton;

Also; William G. Phippen, M.D., of Lancaster; Gerald H. Weiner, M.D., of New Castle; C. Ray Bell, Jr., M.D., of Lebanon; Frederick A. Dry, M.D., of Emmaus; Samuel T. Buckman, M.D., of Wilkes-Barre; Franklin G. Wade, M.D., of Williamsport;

Also; Bruno P. Sicher, M.D., of Kane; Frank E. McElree, M.D., of Greenville; Donald E. Basom, M.D., of McAllisterville; Claus G. Jordon, M.D., of East Stroudsburg; Rudolph K. Glocker, M.D., of Pottstown; Robert L. Gatski, M.D., of Danville.
ville.

Also; Walter J. Filipek, M.D., of Hellertown; J. Mostyn Davis, M.D., of Shamokin; James O. Rumbaugh, Jr., M.D., of Newport; Charles M. Thompson, M.D., of Philadelphia; H.C. Mosch, M.D., of Coudersport; Joseph T. Marconis, M.D., of Pottsville;

Also; Alexander Solosko, M.D., of Meyersdale; Lane H. Webster, M.D., of Wellsboro; Joseph Weightman, M.D., of Lewisburg; Robert L. Taylor, M.D., of Titusville; Donald Jack Furman, M.D., of Warren; Joseph N. McMahan, M.D., of Washington; Emil T. Niesen, M.D., of Honesdale; Leslie S. Pierce, M.D., of Greensburg; John S. Rinehimer, Jr., M.D., of Tunkhannock; and Donald R. Gross, M.D., of York.

THE FIRST ORDER received by the Pennsylvania Medical Cooperative came from Henry H. Fetterman, M.D., of Allentown, chairman of the Society's Council on Medical Service. He is shown above, right, placing his "shopping list" in the hands of H. Robert Davis, M.D., of Boiling Springs, president of the co-op. An application for membership in the mass purchasing plan of the State Society appears on page 10 of this issue.

Pennsylvania Affiliate installs officers

Harry Goldberg, M.D., Philadelphia, was installed as president of the American Heart Association, Pennsylvania Affiliate, during the organization's 26th annual assembly held recently in Pittsburgh. Dr. Goldberg was installed by outgoing president Irvin Jacobs, M.D., of Dallas.

Others assuming top posts were William B. Trice, D.M.D., Erie, chairman of the board, and Lawrence N. Adler, M.D., Pittsburgh, president elect.

The three new vice presidents installed during the assembly are: Lane Giddings, M.D., Wilkes-Barre, assistant chief of laboratory service at the Veteran's Administration Hospital; Anita J. Herbert, M.D., Bradford, immediate past president of the McKean County Medical Society; and C. Robert E. Wells, M.D., Philadelphia, professor of pediatrics at Temple University School of Medicine.

New physicians on the executive committee are Joseph M. Young, M.D., Monessen, past president of the Southwestern Pennsylvania Heart Chapter, and Irvin Jacobs, M.D. Volunteers who will serve on the affiliate board as directors-at-large for three year terms are Joseph S. Brown, Jr., M.D., Lewistown; Charles A. Laubach, Jr., M.D., Danville; David M. Leaman, M.D., Hershey; and Lee H. Shields, M.D., New Cumberland. On the state board of directors for 1975-78 are W. Creighton McClintock, M.D., Pittsburgh, and James O. Rumbaugh, Jr., M.D., Newport.

Solve paperwork problems with new records systems

Management effectiveness, both in medical records and in office operation can be achieved by the use of various forms such as the problem oriented medical record, the one-write accounts receivable and check writing methods, and streamline approaches to filing insurance claims as well as the collection of past due accounts.

The Council on Education and Science has been asked sources of these kinds of record systems. Although the council does not endorse any of these systems as being the most effective, it does call to your attention the following companies who are able to provide a variety of medical record systems and forms:

1. Control-o-fax, Box 778, Waterloo, Iowa 50704.

2. Physicians' Record Co., 3000 S. Ridgeland Ave., Berwyn, Illinois 60402.

3. ROCOM, Div., of Hoffmann-LaRoche, Inc., Nutlee, New Jersey 07110.

4. Safeguard Business Systems, P.O. Box 151, Lansdale, Pennsylvania 19446.

Ambassador program new membership recruitment effo

Approximately 25 physicians from York and Dauphin Counties assembled September 25 at the Sheraton Inn near Harrisburg to launch the Society's newest membership recruitment effort called "The Ambassador Program."

A project of the Society's Council on Professional Relations and Services, the program is designed to recruit new PMS members through one-on-one contact. During the coming weeks the York and Dauphin County ambassadors will call on 86 non-member physicians in the two counties to acquaint them with the Pennsylvania Medical Society and encourage them to become a part of their professional organization.

On hand at the kick-off dinner to offer encouragement and support to the recruiters were: Raymond C. Grandon, M.D., Fifth Councilor District trustee; Robert Poole, M.D., chairman of the Council on Professional Relations and Services; Milton A. Friedlander, M.D., president of the Dauphin County Medical Society; and Thaddeus Lekawa, M.D., president of the York County Medical Society.

If successful, the program is expected to be used as a membership builder throughout the state.

DR. POOLE

DR. GRANDON

DR. LEKAWA

DR. FRIEDLANDER

Bicentennial noted with lecture series

In celebration of the Bicentennial year, the College of Physicians of Philadelphia will present a series of lectures, entitled "World Health in Human Perspective," by internationally known scholars. The series, reviewing the past and looking into the future, will cover subjects ranging from health care in colonial times to contemporary problems of population, nutrition, and energy. Other lectures will consider the implications of recent advances in genetics, government involvement in health care, and the moral development of American children.

The lecture series is scheduled to begin January 7 with a discussion of adaptation to the future by microbiologist René J. Dubos, Ph.D. Other lecturers will include historian Alistair Cooke, speaking on health care in Colonial times; nutritionist Jean Mayer, Ph.D., on U.S. nutrition policy for the 1970s; and environmentalist Paul Ehrlich, Ph.D., on changes in American consumption. A total of eleven lectures will be presented during the Bicentennial year. The series is sponsored by the SmithKline Corporation of Philadelphia.

For further information contact "World Health in Human Perspective," SmithKline Corporation, Department H-20, 1500 Spring Garden Street, Philadelphia, PA 19101.

Private security agents must have physicals

According to Act 235, the Lethal Weapons Training Act, all privately employed security agents who carry lethal weapons as part of their employment must take part in a training program, implemented by the Pennsylvania State Police, on the handling of lethal weapons. Prior to enrollment in the program, security agents must undergo a physical examination, at their own expense, to make certain that there is no disease, condition, or disorder which might interfere with appropriate use of a weapon. Results of the examination must be recorded by physicians on a special form provided by the State Police.

Passed in October 1974, the training act defines lethal weapons as including but "not limited to, firearms, mace and other weapons calculated to produce death and serious bodily harm." The deadline for enrolling in a program is December 31, 1975.

For further information regarding the training program or examination forms, contact the Director, Bureau of Training and Education, Pennsylvania State Police, Dept. 3, P.O. AA, Hershey, PA 17033.

At Washington hearings

Society position on national health insurance stated

David S. Masland, M.D., then PMS president elect, testified recently on national health insurance before members of the House Ways and Means Committee's subcommittee on health. Like the six other physicians who testified before the subcommittee, Dr. Masland spoke against a high degree of Federal interference in any health insurance program.

"Many existing Federal programs have already demonstrated their inefficiency. I would contrast this to the Blue Shield and Blue Cross plans in Pennsylvania with their low administrative costs—approximately 10 percent of the premium dollar. It would seem ill-advised then to transfer the functions now provided efficiently by private carriers to a Federal bureaucracy."

He pointed out that a national health insurance program could produce a paperwork explosion which would mean "additional expense to the health care system."

Dr. Masland also stated his concern for social factors, which " . . . have the biggest impact on national health" and to which national health insurance does not address itself. He said that the freedom of both the physician and the patient to continue or discontinue a relationship is essential to good care.

"It is therefore imperative that patients and physicians have the right to choose their own health insurance plan; to choose the delivery system in which they wish to participate and how they wish to pay for it. This freedom of choice is not just a nicety, it is a necessity for good care," he said.

Prior to the testimonies of the seven physicians, the subcommittee had heard from a panel of foreign physicians who were critical of the health insurance systems in their own countries and warned lawmakers not to allow government control of health care in the United States.

PHYSICIANS testifying before the subcommittee on health are, left to right: John H. Burkhardt, M.D., Knoxville, Tennessee; John Hamilton, M.D., Rochester, New York; Marvin N. Lymberis, M.D., Charlotte, North Carolina; Clinton S. McGill, M.D., Portland, Oregon; Dr. Masland; Brooker L. Masters, M.D., Freemont, Michigan; and Donald Quinlan, M.D., Northfield, Illinois.

New information required on medicare claims

Pennsylvania Blue Shield is now complying with new Social Security Adminstration regulations requiring that certain information be included on medicare claims. The prescribed reporting requirements involve three specific items: diagnosis, eye refractions, and payment on account.

Diagnosis—When a Request for Medicare Payment form is prepared, the specific diagnosis for which the services were performed should be shown in Section 7D.

If a receipted bill is prepared for the patient for submission to medicare, the diagnosis must be included on the receipt. When a sensitive diagnosis is involved, an International Classification of Disease (ICDA) code may be indicated.

Eye refractions—Eye refraction procedures are not covered under the medicare program. In order for correct reimbursement to be made for visits involving eye care, it is necessary for the doctor to specify whether a refraction was performed and to indicate separate charges.

If itemized charges cannot be obtained, SSA has advised that payment for eye care visits will be based on the following:

1. A 20 percent reduction will be made in the reasonable charge for all comprehensive or extended visits.

2. A 33 1/3 percent reduction will be made in the reasonable charge for a reexamination.

Payment on account—A receipt from a doctor which states only "payment on account," "balance due," etc., is unacceptable for claims processing purposes. When a receipt is issued to a patient, the specific services provided should be indicated. If a receipt is given for a deductible amount or 20 percent coinsurance for which the patient is liable, this information should be indicated on the receipt.

PMS SUPERMARKET NOW OPEN

Get big savings on all your office medical supplies. Buy from the Pennsylvania Medical Cooperative and save as much as 50% on a single item. There are more than 250 different kinds of quality products in the Co-op warehouse ready for immediate delivery. Orders are filled within 24 hours. The Co-op buys directly from manufacturers and passes the savings on to you. Shop the PMS Supermarket and save.

The Pennsylvania Medical Cooperative is an exclusive PMS membership benefit. What does it cost to join the Co-op? It doesn't, **it pays**—on the average enough to cover your lifetime $200 Co-op membership fee, and your PMS and county society dues for the year. Use the application below.

Pennsylvania MEDICAL Cooperative

(Please make checks payable to the Pennsylvania Medical Cooperative.)

NAME: _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP _____

TELEPHONE NUMBER: _____

I am a member of the Pennsylvania Medical Society. Please enroll me as a member of the Pennsylvania Medical Cooperative. Enclosed you will find a check in the amount of $200 to cover the membership requirement. It is my understanding that this is a one-time subscription entitling me to a vote in the affairs of the Cooperative and giving me the right to purchase all medical supplies offered by the Cooperative.

PENNSYLVANIA MEDICAL COOPERATIVE, 3617B Simpson Ferry Road, Camp Hill, PA 17011

House of Delegates charts activities for future

The State Society's House of Delegates mapped plans for the future at the 1975 Annual Session, moving to keep the special house session on malpractice in recess while urging the House of Representatives to concur in Senate amendments to H.B. 1367. Delegates went on record to seek additional corrective measures in 1976.

The House also approved the concept of a medical defense unit to fight out of court settlement of questionable malpractice cases, in view of the growing trend on the part of professional liability insurance companies to seek such settlement. The approval was of a recommendation by the incoming president, David S. Masland, M.D., whose address appears on page 32 of this issue.

Delegates also reaffirmed the use of patient contracts and voluntary binding arbitration as a means of avoiding lengthy court proceedings for both patients and physicians. The recommendation came from A. Reynolds Crane, M.D., immediate past president, whose address will appear in the December issue of PENNSYLVANIA MEDICINE.

Additionally in grappling with the malpractice crisis, delegates approved a recommendation that physicians testifying outside their specialty face the possibility of expulsion from the State Society. "The problem of the professional expert witness has been with us for many years but has not been openly confronted by organized medicine," the House said. In the future it will be considered unethical for a physician to testify as an expert witness outside his specialty or a logical extension of that specialty.

Education requirement reaffirmed

Mandatory continuing education as a prerequisite for Society membership was reaffirmed by the House, acting on a recommendation of the Reference Committee on Education and Science. The reference committee recommended that revisions on the requirements and deadlines be evaluated before considering making the mandatory requirement voluntary. The October issue of PENNSYLVANIA MEDICINE outlined new, simplified methods of complying and printed a reporting form.

Health Care Act opposed

Delegates voiced strong opposition to the Shapp Administration's Comprehensive Health Care Act as represented in S.B. 10 and H.B. 853. The report of the Reference Committee approved by the House said, "In many respects these bills represent a more significant threat to medical practice than our quest for a solution to the malpractice crisis . . . this House should once again go on record as denouncing all of the ingredients in these bills with the exception of a sensible 'certificate of need' for Pennsylvania."

Unified membership approved

Unified membership with the AMA, recommended by Dr. Crane to "better cope with the increasingly dangerous restrictions placed upon the practice of medicine by . . . a burgeoning bureaucracy" was approved by the House, but will require changes to the Constitution and Bylaws, which means the earliest effective date would be January 1977.

House acts on Blue Shield

Delegates approved a resolution calling on Blue Shield to abolish the geographic differential in prevailing fee payments and develop one charge class for the entire state. Resolution 75-19, calling for "equal pay for equal work" was introduced by Perry County.

Other actions

Delegates also:

Approved an action by the Board of Trustees to sue the Department of Health if necessary to block implementation of regulations concerning laboratories in physicians' offices;

Ordered the Committee on Relationships with Allied Professions to draft a new statement on the role of nurses and nurse practitioners which would make physicians responsible for directing patient care;

Maintained dues for 1976 at $150;

Called on the attorney general to render an opinion clarifying current abortion statutes and the obligations of the Department of Public Welfare.

JONATHAN E. RHOADS, M.D., of Philadelphia, left, received the Society's coveted Distinguished Service Award from David S. Masland, M.D., newly installed president, at the Annual State Dinner.

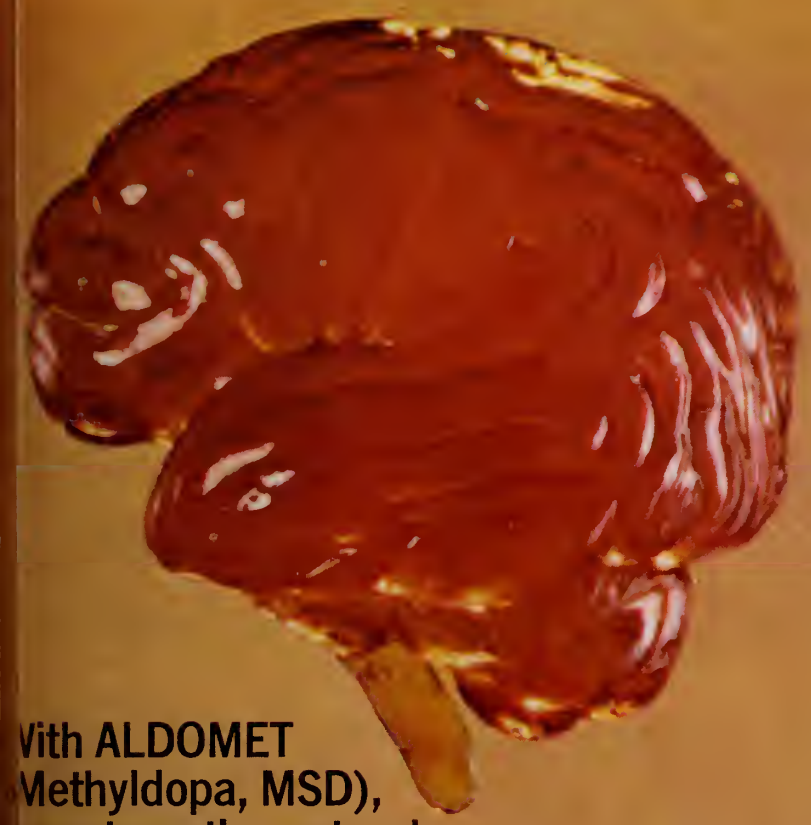
In hypertension,
ALDOMET® (METHYLDOPA|MSD)
usually offers more than effective lowering of blood pressure...

With ALDOMET (Methyldopa, MSD), existing renal function is usually unchanged

ALDOMET has no direct effect on renal function. When used in effective doses, ALDOMET usually does not reduce glomerular filtration rate, renal blood flow, or filtration fraction.

With ALDOMET (Methyldopa, MSD), cardiac output is generally unchanged

ALDOMET has no direct effect on cardiac function. When ALDOMET is used in effective doses cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is slowed.



Vith ALDOMET Methyldopa, MSD), ymptomatic postural ypotension is infrequent

LDOMET reduces both supine and standing blood pressure. ess frequent symptomatic postural hypotension is experienced ith ALDOMET than with many other antihypertensive agents. xercise hypotension and diurnal blood pressure variations rely occur.

or hypertension

ABLETS, 250 mg, 500 mg, and 125 mg

ALDOMET®

METHYLDOPA|MSD)

unique antihypertensive agent

.DOMET is contraindicated in active hepatic disease, persensitivity to the drug, and if previous methyldopa erapy has been associated with liver disorders. It is t recommended in pheochromocytoma. s important to recognize that a positive Coombs test, molytic anemia, and liver disorders may occur with ethyldopa therapy. The rare occurrences of hemolytic anemia liver disorders could lead to potentially fatal complica- ns unless properly recognized and managed. For more tails see the brief summary of prescribing information.

MSD MERCK SHARP & DOHME

r a brief summary of prescribing information, please see following page.

addendum

MSD MERCK SHARP & DOHME

to further simplify therapy for many patients

now available

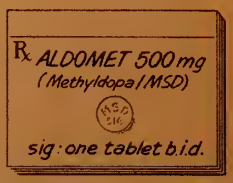
ALDOMET® 500 mg
(METHYLDOPA|MSD)

- **often more practical to prescribe**
- **easier for patients to remember**

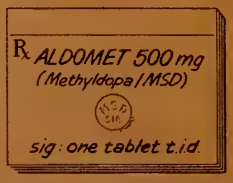
Now offered in addition to the standard 250-mg tablet, the new ALDOMET 500 mg tablet is a patient convenience. An especially important one, since in hypertension convenience of the dosage schedule is one factor that can make the difference in compliance of the patient. The minimum daily dose of ALDOMET is 250 mg b.i.d. The usual starting dose is 250 mg t.i.d. Dosage is adjusted as necessary by adding or deleting 250 mg or 500 mg at intervals of not less than two days. The maximum dose is 3.0 g per day.

Examples of b.i.d. or t.i.d. dosage convenience provided by ALDOMET 500 mg within the usual daily dosage range of 500 mg to 2.0 g:

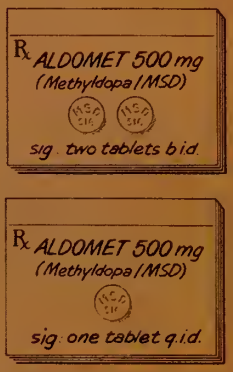
1.0-g daily dose =



1.5-g daily dose =



2.0-g daily dose =



NOTE: Tablets shown are not actual size.

in hypertension

ALDOMET® (METHYLDOPA|MSD)

usually lowers blood pressure effectively

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movemen occur in patients with severe bilateral cerebrovasc lar disease. Patients may require reduced doses anesthetics; hypotension occurring during ane thesia usually can be controlled with vasopressor Hypertension has recurred after dialysis in patien on methyldopa because the drug is removed by th procedure.

Adverse Reactions: *Central nervous syste* Sedation, headache, asthenia or weakness, usua early and transient; dizziness, lightheadednes symptoms of cerebrovascular insufficienc paresthesias, parkinsonism, Bell's palsy, decrease mental acuity, involuntary choreoathetotic mov ments; psychic disturbances, including nightmar and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angi pectoris. Orthostatic hypotension (decrease da dosage). Edema (and weight gain) usually relieve by use of a diuretic. (Discontinue methyldopa edema progresses or signs of heart failure appea

Gastrointestinal: Nausea, vomiting, distention, co stipation, flatus, diarrhea, mild dryness of mouth, so or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundic liver disorders.

Hematologic: Positive Coombs test, hemolyti anemia. Leukopenia, granulocytopenia, throm bocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlarge ment, gynecomastia, lactation, impotence, decrease libido, dermatologic reactions including eczema an lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited t 500 mg daily when given with antihypertensive other than thiazides. Tolerance may occur, usuall between second and third month of therapy; in creased dosage or adding a thiazide frequentl restores effective control. Patients with impaire renal function may respond to smaller doses. Syn cope in older patients may be related to increase sensitivity and advanced arteriosclerotic vascula disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, contain ing 250 mg methyldopa each, in single-uni packages of 100 and bottles of 100 and 1000 Tablets, containing 500 mg methyldopa each, i single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSI representative or see full prescribing informa tion. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD MERCK SHARP & DOHME

Annual Session reflections show leaders active

DR. CRANE ADDRESSES HOUSE OF DELEGATES

SPEAKER LOVETTE VISITS DISTRICT CAUCUSES

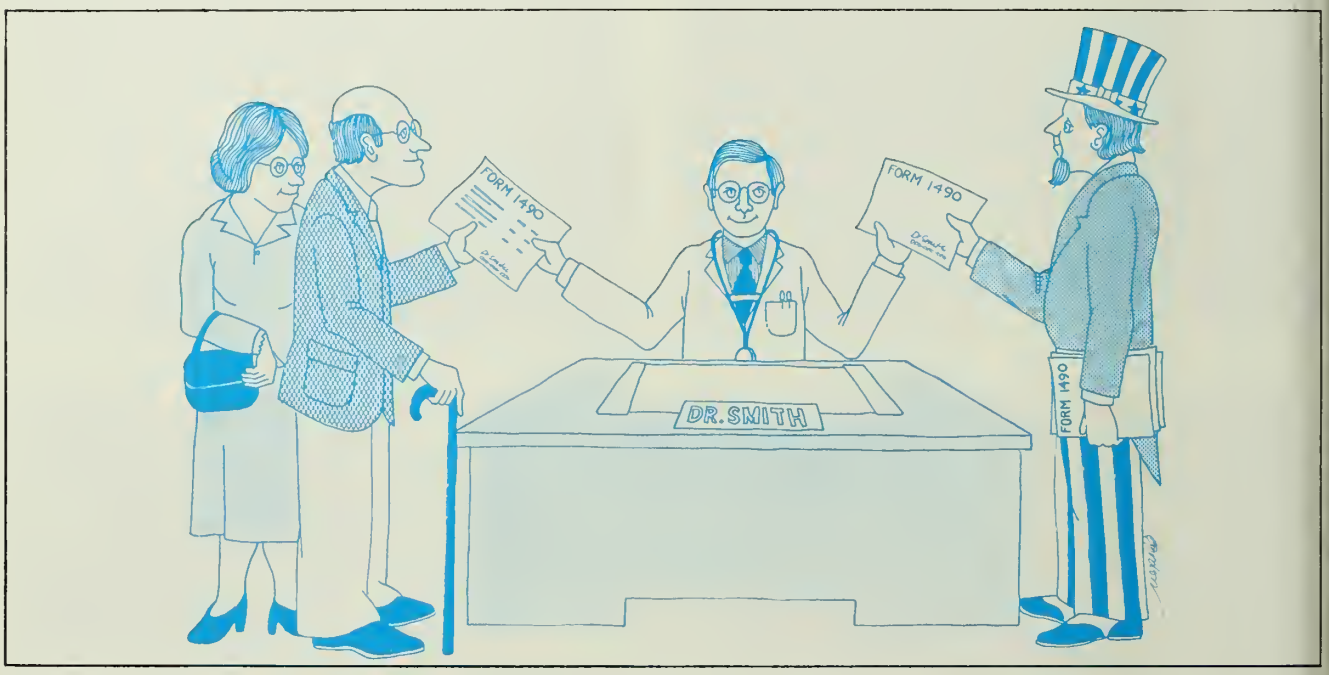
TELLERS PRESIDE AS DELEGATES VOTE

THE HEAD TABLE AT THE STATE DINNER

SHOWN at the reorganization meeting of the Board of Trustees are, left to right, George A. Rowland, M.D., newly elected chairman; William C. Ryan, M.D., vice chairman; and Carol N. Maurer, M.D., and Richard L. Huber, M.D., new members of the Board.

CASH FLOW TOO SLOW?

Take assignment! But if you don't, at least use the medicare 1490 form as your office bill.



ADVANTAGES

- *REDUCES* ERRORS . . . 1490 FORM AIDS IN CORRECT REPORTING.
- *SPEEDS* MEDICARE PAYMENT TO PATIENT . . . IMPROVED DOCTOR-PATIENT RELATIONSHIP.
- *REDUCES FOLLOW-UP CONTACTS* . . . LESS NEED FOR PRE-PAYMENT CALLS, LETTERS, ETC. FOR MISSING INFORMATION.
- *SAVES* PAPER COSTS . . . PERSONAL PRE-PRINTED DOCTOR-IDENTIFYING BILL FORMS (1490's) ARE FURNISHED FREE.

Note: These tips on government programs are designed to aid doctors in their billing practices. We suggest that office assistants keep these for future reference. Other tips were furnished in the August and October, 1975 issues of PENNSYLVANIA MEDICINE. Copies can be obtained by writing to the Editor, PENNSYLVANIA MEDICINE.

I.R. Perkin, Director
Medicare Operations
Pennsylvania Blue Shield

If your angina patient* isn't having 3 out of 4 better days than usual... try Cardilate®
(ERYTHRITYL TETRANITRATE)

*Please note: unstable angina patients may be refractory to all long-acting nitrates.

NDICATIONS. For the prophylaxis and ong-term treatment of patients with fre- uent or recurrent anginal pain and re- uced exercise tolerance associated with ngina pectoris, rather than for the treat- ent of the acute attack of angina pec- oris, since its onset of action is somewhat ower than that of nitroglycerin.

RECAUTIONS. As with other effective trates, some fall in blood pressure may ccur with large doses.

Caution should be observed in admin- tering the drug to patients with a history recent cerebral hemorrhage, because the vasodilatation which occurs in the ea. Although therapy permits more rmal activity, the patient should not be lowed to misinterpret freedom from ginal attacks as a signal to drop all strictions.

IDE EFFECTS. No serious side effects ve been reported. In sublingual therapy tingling sensation (like that of nitro- ycerin) may sometimes be noted at e point of tablet contact with the mucous embrane. If objectionable, this may be itigated by placing the tablet in the uccal pouch. As with nitroglycerin or her effective nitrites, temporary vascular eadache may occur during the first few ys of therapy. This can be controlled by mporary dosage reduction in order to low adjustment of the cerebral hemo- ynamics to the initial marked cerebral asodilatation. These headaches usually sappear within one week of continuous erapy but may be minimized by the dministration of analgesics.

Mild gastrointestinal disturbances occur ccasionally with larger doses and may e controlled by reducing the dose tem- orarily.

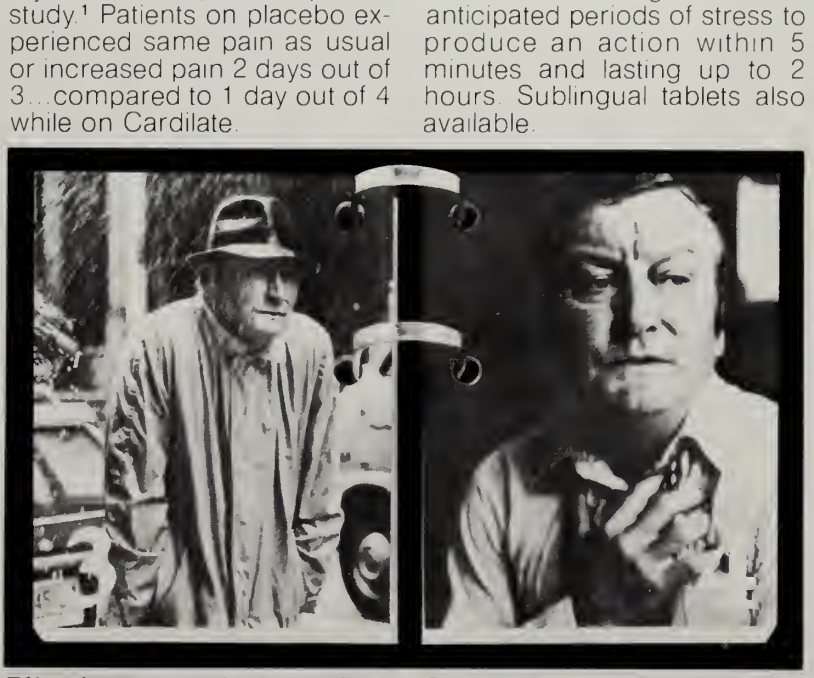
UPPLIED. 10 mg chewable tablets, bot- e of 100. Also 5, 10 and 15 mg scored blets in bottles of 100. 10 mg scored blets also supplied in bottle of 1,000.

Also available: Cardilate® P brand rythrityl Tetranitrate with Phenobarbital* (Warning: may be habit-forming)

Russek HI: AM J M Sc 239:478, 1960

"Pain days" significantly reduced with Cardilate® (erythrityl tetranitrate) in 48-patient study.[1] Patients on placebo experienced same pain as usual or increased pain 2 days out of 3...compared to 1 day out of 4 while on Cardilate.

Rapid-acting chewable tablets (10mg) preferred by many patients. Should be given before anticipated periods of stress to produce an action within 5 minutes and lasting up to 2 hours. Sublingual tablets also available.



Effective prophylaxis against attacks; increases exercise tolerance. Serious side effects have not been reported in 20 years' clinical use.

Cardilate can save patients money; is less expensive than many popular long-acting nitrates. 20% to 30% savings not uncommon...also helps reduce need for nitroglycerin.

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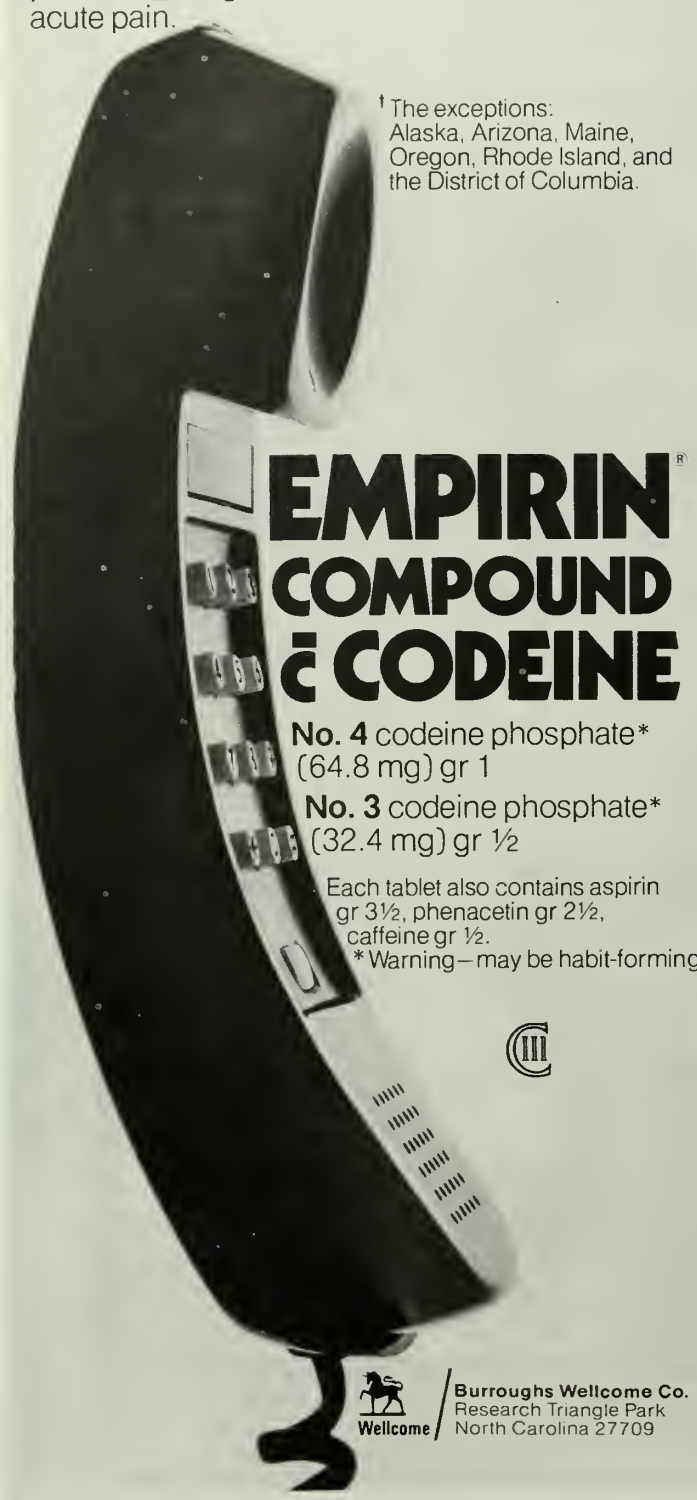
† The exceptions: Alaska, Arizona, Maine, Oregon, Rhode Island, and the District of Columbia.



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Each tablet also contains aspirin gr 3½, phenacetin gr 2½, caffeine gr ½.

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Rheumatoid arthritis can sometimes spread like wildfire, with joint after joint going up inflamed: "The usual onset is manifested by spotty joint involvement but an acute onset of symmetrical polyarthritis may be noted."*

If aspirin fails, consider Butazolidin alka. Giving one capsule four times a day often provides prompt, pain-relieving, anti-inflammatory action to help restore joint mobility. The results you can get within a week can be maintained on as little as one or two capsules daily.

Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions. For full details, please read the prescribing information. It's summarized on the back of this page.

Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.

Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
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Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Fire fighter for arthritic flare-ups.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy, blood dyscrasias, renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug, its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.

(B)98-146-070-J (10/71)

For complete details, including dosage, please see full prescribing information.

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cardiovascular brief

PENICILLIN: MULTIPLE APPLICATIONS IN RHEUMATIC PATIENTS

This is the first of two articles prepared for the American Heart Association, Pennsylvania Affiliate, by Sidney Friedman, M.D., chairman of the Affiliate's Committee on Cardiovascular Disease in the Young, and C. Robert E. Wells, M.D., committee cochairman and vice president.

Penicillin is a very valuable antibiotic in the management of patients with streptococcal infection, rheumatic fever and rheumatic heart disease. There are a number of distinct indications for its use, each requiring a specific preparation, dosage level and duration of administration.

There are several fortuitous bacteriologic facts which enhance the value of penicillin in the prevention of rheumatic fever and in the treatment of its complications. The first of these is the exquisite sensitivity of the beta-hemolytic streptococcus to penicillin. Low blood levels of penicillin which would be ineffective in the treatment of other bacterial infections, are bacteriocidal in their action on this particular organism. Second, despite the use of penicillin in the treatment and prevention of beta-hemolytic streptococcal infections over a period of almost four decades, no strains of Group A beta-hemolytic streptococci have emerged which are resistant to this antibiotic. Finally, a high percentage of alpha hemolytic streptococci which are present in the transient bacteremia following dental and oral surgery are sensitive to the bacteriocidal action of penicillin. Thus, penicillin plays a unique role in the management of rheumatic patients. An understanding of the specific uses and limitations of this antibiotic in each of the individual applications is essential for the proper management of rheumatic patients.

Secondary Prevention of Rheumatic Fever

Almost 40 years have passed since Coburn and Moore[1] demonstrated that the administration of small doses of sulfonamides was effective in preventing streptococcal infections and hence in preventing rheumatic recurrences among known rheumatic subjects. Several years thereafter small doses of oral penicillin were found to be equally effective, particularly among pediatric patients in whom streptococcal infection and rheumatic recurrences are most frequent. This method of rheumatic fever prevention is *consistently* successful. Apparent breakthroughs are almost uniformly based on failure in administration of the drugs.

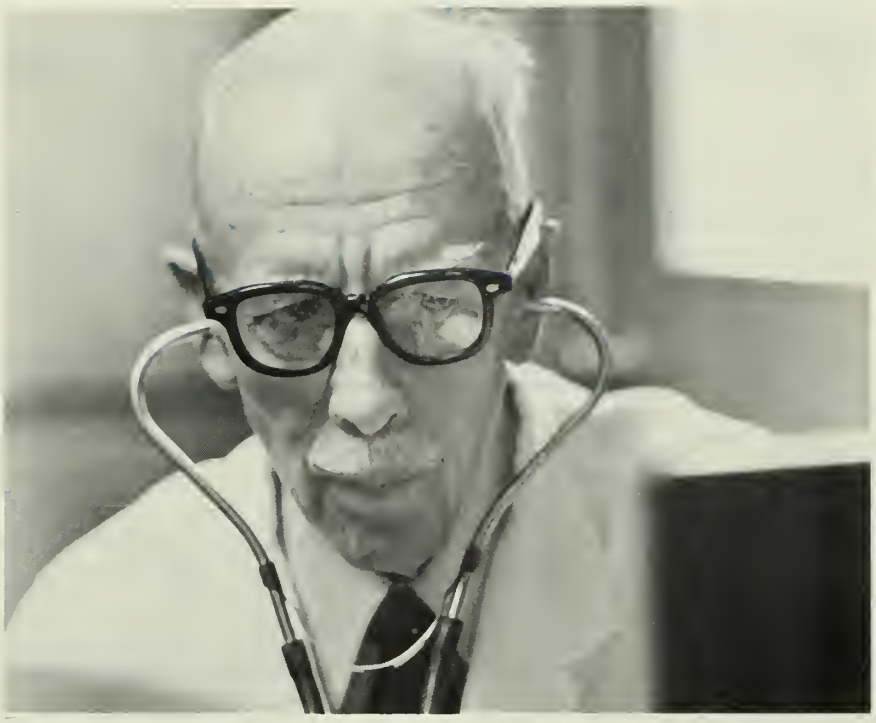
Thus, any patient with a firm diagnosis of rheumatic fever, particularly if cardiac involvement has occurred with the initial episode, should be placed on a program of anti-streptococcal prophylaxis for an indefinite period of time. The present dosage recommendation for penicillin is 400,000 units of oral penicillin G daily, taken on a fasting stomach. Even more effective is a single intramuscular injection of benzathine pencillin given at four week intervals. The intramuscular route is best applied in a "captive" patient-group.

Oral penicillin G is used by most rheumatic fever clinics. The undesirable manifestations of penicillin administration are extremely low in the pediatric age group, and the cost of penicillin has fallen below that of other effective drugs. In the rare instances of sensitivity to penicillin, sulfonamides are the second choice. In the case of sensitivity to both penicillin and sulfonamides, erythromycin is the third choice for secondary prevention of rheumatic fever.

Although the more prevalent months for streptococcal infection are in the late winter and early spring in Pennsylvania, streptococcal infection may occur at any season of the year. For this reason, anti-streptococcal prophylaxis should be continued throughout the year. Prophylaxis should be initiated as soon as the diagnosis of active or inactive rheumatic fever is made. Prophylaxis is especially important in hospitalized patients who are exposed to the increased hazard of contact with streptococcal carriers in hospital wards.

1. **Coburn, A.F., and Moore, L.F.** : The Prophylactic Use of Sulfanilamide in Streptococcal Respiratory Infections, with Special Reference to Rheumatic Fever, J. Clin. Invest. *18:* 147, 1939.

MDs in the news



ROBERT PARKS BANKS, M.D., 81, one of the oldest working graduates of Temple University School of Medicine, has practiced medicine in Mifflintown for over 54 years. When he first began his practice he made house calls in a horse drawn sleigh and charged $2 for his efforts. Dr. Bob, as he is called by his older patients, still makes house calls, works at the well baby clinic in Port Royal, and holds office hours five days a week. Even at his age, Dr. Banks feels that he cannot "just walk away" from his practice since Juniata County has so few doctors. "Too many people depend on me," he says.

The Pennsylvania Public Health Association recently awarded **Leonard N. Wolf, M.D.**, an honorary membership for his contributions to the field of public health. Dr. Wolf, executive director of the Greater Delaware Valley Regional Medical Program, was honored for his service as a director of the Northeast Pennsylvania Health and Hospital Planning Council, chairman of the board of directors of the Health Care Management Corporation of Northeastern Pennsylvania, a member of the Society's advisory committee on health care, and acting chairman of the State Advisory Council for Comprehensive Health Planning.

Joanna Chapin, M.D., a second year resident in psychiatry at The Institute of Pennsylvania Hospital, was recently named a Falk Fellow of the American Psychiatric Association. The purpose of the fellowship is to identify "promising young leaders" in psychiatry and involve them in the policymaking activities of the association.

Barry H. Dvorchik, M.D., recently received a one year basic research grant from the National Foundation-March of Dimes. Dr. Dvorchik's research will involve the effects of various widely used drugs on the liver of the fetus. Dr. Dvorchik is assistant professor of obstetrics and gynecology and pharmacology at The Milton S. Hershey Medical Center.

Thomas V. Murray, M.D., was recently appointed the first medical director of Sharon General Hospital. Dr. Murray is former chief of surgery at the hospital.

Henry H. Schmidek, M.D., Berwyn, was named professor and chairman of the department of neurosurgery at Hahnemann Medical College and Hospital recently. He will oversee the development of the new department, which was formerly a division of the department of surgery.

F. William Sunderman, M.D., professor of pathology and director of the Franklin-Hahnemann Institute at Hahnemann Medical College, received the Ward Burdick Award of the American Society of Clinical Pathologists at a meeting held recently in Chicago. The presentation was followed by Dr. Sunderman's award lecture entitled "River of Years." Dr. Sunderman is a founding fellow of the College of American Pathologists, a founder and the first president of the Association of Clinical Scientists, and past president of the American Society of Clinical Pathologists. He is a member of the Governor's Task Force on Environmental Health and directs the Insitute of Clinical Science, Inc., and the Proficiency Test Service which he founded in 1949 to provide clinical laboratories with monthly self-audit and advisory materials.

Oscar V. Batson, M.D., emeritus professor of anatomy at the University of Pennsylvania School of Medicine, recently received the 1975 Henry Gray Award from the American Association of Anatomists. The award was established to honor "sustained and meritorious service" in the field of anatomy.

The Committee on Public Health of the College of Physicians of Philadelphia and Region I, the Public Health Association recently presented the 19th Arthur Parker Hitchens lecture in honor of **Claude P. Brown, M.D.**, who celebrated his 100th birthday in October. **Norman R. Ingraham, Jr., M.D.**, former Health Commissioner of the Pennsylvania Department of Public Health and past president of the Pennsylvania Public Health Association, presented a lecture on "The Golden Anniversary of the Pennsylvania Public Health Association: a 50 year Historical Prospective."

David B. Soll, M.D., was recently appointed professor and chairman of the new department of ophthalmology at Hahnemann Medical College and Hospital. Dr. Soll has been a pioneer in the research and development of operations for correction of eyelid problems, glaucoma, and cataracts, and invented devices for children born without eyes. Additionally, Dr. Soll served as program chairman for the American Society of Ophthalmic Plastic and Reconstructive Surgery Symposium, held recently in Dallas, Texas. He is a member of the National Committee on Trauma of the American College of Surgeons, medical advisor to the American Society of Ocularists, and a charter member of the American Society of Ophthalmic Plastic and Reconstructive Surgery.

DR. SOLL

DR. MASTROIANNI

Luigi Mastroianni, Jr., M.D., Haverford, chief of obstetrics and gynecology in the Woman's Hospital division of the Hospital of the University of Pennsylvania, was recently named president elect of the American Fertility Society at the organization's 31st annual meeting in Los Angeles. Dr. Mastroianni is the William Goodell professor and chairman of obstetrics and gynecology in the University of Pennsylvania School of Medicine. He has been a leader in the American Fertility Society for many years and is currently editor of the Society's official journal, FERTILITY AND STERILITY.

William Bouzarth, M.D., recently received the Pennsylvania Public Health Association's (PPHA) special honored for his service as chairman public health. Dr. Bouzarth was awarded for his service as chairman of the Emergency Medical Task Force for Pennsylvania Comprehensive Health Planning, 1972-74, and as chairman of the Society's Commission on Emergency Medical Services 1970-74. Dr. Bouzarth is a member of the American College of Surgeons board of regents' special task force to determine optimal criteria for hospital resources for care of seriously injured patients.

Geisinger Medical Center, Danville, recently added two new physicians, **Gregory W. Benkovic, M.D.**, and **Lawrence S. Greenfield, M.D.**, as associates in the new department of general internal medicine, which is under the direction of **James A. Collins, Jr., M.D.**, chairman of the division of medical services, and chairman of the Society's Council on Education and Science. Two physicians, **Duane W. Ebaugh, M.D.**, and **Robert C. Spahr, M.D.**, were appointed to the department of pediatrics. Dr. Ebaugh will specialize in neonatology and direct newborn services and the neonatal intensive care unit.

Arnold S. Relman, M.D., will spend the 1975-76 academic year at Oxford University under a faculty scholar award from the Josiah Macy, Jr., Foundation. His research is on the biochemistry and physiology of the kidney, particularly how ammonia production is controlled. Dr. Relman is Frank Wister Thomas professor of medicine and chairman of the department at the University of Pennsylvania School of Medicine.

Leonard S. Girsh, M.D., was guest speaker recently at the United States Public Health Hospital in Santa Fe, New Mexico. He spoke on allergic disease, diagnosis, and treatment.

James Herbert Robinson, M.D., clinical associate professor of surgery at Jefferson Medical College, was recently appointed associate dean and director of minority affairs at Jefferson. Dr. Robinson is a past member of the board of directors of the Philadelphia County Medical Society and is currently on the board of censors of that society.

Miroslav Klain, M.D., was named associate professor of anesthesiology/critical care medicine at the University of Pittsburgh School of Medicine recently. Dr. Klain is director of research in the department of anesthesiology, a consultant to the National Heart and Lung Institute project on heart powered pacemakers.

THE DELAWARE VALLEY Sudden Infant Death Syndrome Resource Center, the valley's first center providing complete services to families suffering a "crib death," opened recently at the Children's Hospital of Philadelphia. The center, funded by a grant from the Department of Health, Education, and Welfare, is a cooperative effort of Children's Hospital, the city medical examiner's office, St. Christopher's Hospital for Children, the Community Nursing Service, and the Pennsylvania Guild for Infant Survival. Shown attending the center's opening reception are, left to right, Robert L. Catherman, M.D., and James McGovern, both of the medical examiner's office, Marie Valdes-Dapena, M.D., SIDS researcher, St. Christopher's Hospital, and Charles E. Ingersoll, president of Children's Hospital.

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ROER

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editorials

Politics and medicine—synthesis or antithesis

"Politics" and "politicians" did not develop the unsavory connotations we attach to them today until the immediate post-Civil War period about 100 years ago. With the rise of carpetbaggers and big city bossism throughout the latter part of the Nineteenth Century, the politician was looked upon as a man with very little ability and intellect. It was during this period that the unethical practice of "buying" elected officials began, signaling the rapid decline in the respectability of statecraft.

With a few notable exceptions, the Twentieth Century has produced leaders of sufficient quality to restore a measure of dignity to politics and public office. Woodrow Wilson wrote, "Tolerance is an admirable intellectual gift; but it is of little worth in politics. Politics is a war of causes; a joust of principles." Under our system of government, one must either take to a soapbox to espouse his cause or rely upon an elected official to do so formally. The deficiency of relying on the politician to champion a principle is most poignantly depicted by the current nationwide malpractice crisis. Organized medicine has asked for and demanded legislation to deal with the problem but the lawmakers' response has been slow. Our counsel and recommendations merit little serious governmental attention.

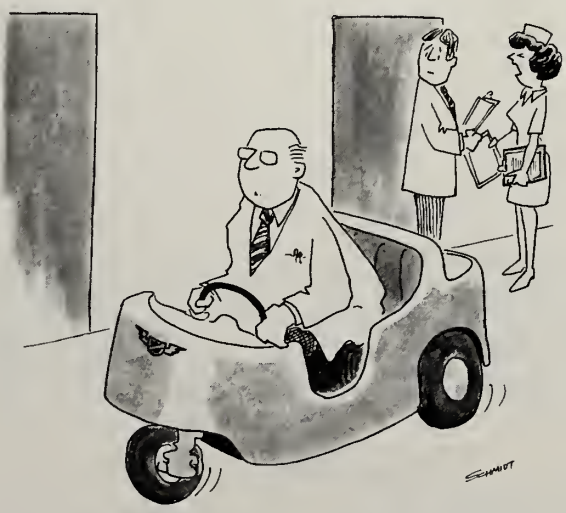
As a result, there has been a frightening rise in radicalism within the medical profession in the form of strikes and unionism. This method assuredly attracts attention to the physicians' plight but it tends to produce crises that outweigh the immediate problems. Worse, it can sway public sentiment against the doctor. Issues become difficult to define in the emotional upheaval that follows and although we may win the battle, we will probably lose the war.

The radicalism we are witnessing currently is generated as a basic defense mechanism, and has a negative effect. Discussion produces compromises which are slow in materializing and are usually a draw at best. That is not to say that debate is bad, but both parties to a compromise must necessarily be left unsatisfied on some issues. A positive, offensive approach for which we have been grasping might best be found through the ballot box in the M.D. candidate.

What does the M.D. candidate have to offer as an elected official? Educated, and presumably intelligent, he is sincere and patient. He is used to devoting long and rather irregular hours to his profession. He is generally a respected member of his community and is active in civic functions. But most of all, he knows people and is used to dealing with them.

The attainment of a medical degree does not imply the abrogation of citizenship. It is the right and privilege of every citizen to aspire to an elected office provided he meets the constitutional qualifications for that office. With a formal vote and a platform from which to speak, the physician can do much for medicine and for the public. The synthesis of medicine and politics through the M.D. candidate can serve to improve the position of the former and the image of the latter.

David A. Smith, M.D.
Medical Editor



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practice management

Personnel management 'critical' factor in medical practice

LEIF C. BECK, LL.B.
VASILIOS J. KALOGREDIS, J.D.

Bala Cynwyd

'A good office requires the expenditure of some physician time and attention, and personnel is the area in which that personal doctor investment pays off the most. The amount of time and thought necessary is really insignificant to the doctor's total work, but his failure to give that little attention can be disastrous.'

We have discussed some aspects of office personnel management before, but we feel that the subject is so important that it must come before our readers again and again. Therefore, a few selected topics related to "people management" will be presented in this and next months' articles.

The importance of a good staff

Without the slightest doubt, obtaining, training, and managing lay personnel is the most critical factor for a medical office. In a practice lacking effective and conscientious aides, efficiency is compromised, collections are delayed, and medical care itself may be jeopardized. With good employees, on the other hand, these problems may be avoided while the physician's emotional state might be protected from constant annoyances and "snafus."

Perhaps these general statements seem self evident, yet it is surprising that so many practices are plagued by employee problems. Where office morale seems low and an air of tension pervades the doctor and his aides, the difficulty can be sensed by the patients while it "hassles" the doctor. Where there is an inordinate amount of employee turnover, there are continuing interruptions for interviewing job applicants, training newly employed people, and correcting their normal early mistakes.

Probably nothing is more costly or more disruptive than employee turnover. Employees in most secretarial, nursing, and even clerical jobs tend not to contribute effectively for three months after hire, and hence a good aide's

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.

quitting is likely to cause difficulties for a period extending far beyond the date she is replaced. As a result, the economic "cost" of replacing her may far exceed the doctor's time and money necessary to create a job climate which would have retained her.

Personnel costs in almost every practice is the single largest factor making up overhead. They would normally range between 10 percent and 17 percent of a practice's gross income, with the higher percentages likely in practices with heavier primary care responsibilities. In some excellent offices the payroll percentage will be even higher, probably indicating extensive use of lay help in rendering care. Such circumstances may be very desirable, and concern over unusually high personnel costs must be kept in the perspective of what they are producing.

Sexism in the office

This article generally refers to aides in the feminine form and to doctors in the masculine. It is done merely out of convenience to the reader and in recognition of the presently typical pattern. There are, however, an increasing number of male office aides and a far more dramatically increasing number of excellent female physicians. Every medical office should be most receptive to these developments, remaining open to employment of either sex. Not only does the Federal law require such "equal opportunity" for the sexes, good professional and business sense also dictates it.

Furthermore, little can be so degrading to a good staff as the sexist references to "the girls," the "office girls," and the like. The aides should be mature women (or men), sharing important responsibilities in medical care, even if their skills are only clerical. An office's patients should feel that confidence, but the impression can be harmed by the doctor's own words.

The office will function most successfully if each person, from part time file clerk up to senior physician, shares a sense of importance. This feeling will flow from the doctor's attitude towards his lay staff, from his conveying to them a respect for their jobs and for them as people. Such respect is reinforced by references to each aide by name or by job title, by use of words like "assistant" or "aide" and by corresponding refrain from calling them "my girls."

Investment of physician time

A good office requires the expenditure of some physician time and attention, and personnel is the area in which that personal doctor investment pays off the most. The amount of time and thought necessary is really insignificant to the doctor's total work, but his failure to give that little attention can be disastrous.

For example, while a senior aide or aides might handle most of the work in recruiting a new employee, the physician should carefully structure the procedures to be followed. Similarly, a doctor should periodically schedule a staff meeting to keep open lines of communication and avoid festering feelings. And he should put into writing his office's employee policies, heading off misunderstandings and questions which may take far more of his time and attention later on. The devotion of some time to such aspects of personnel management on a *deliberate* and *regular* basis is essential.

No physician is really "too busy" for his office staff. Those who claim not to have the time for such management are often too busy exactly because their offices have been handicapped by his inattention. While some management time can be avoided by use of an "office manager," equivalent time must then be given to review and supervision of that manager. Lack of leadership at the physician level hurts capable managers just as it confuses the work of the employees themselves.

Naming an office manager

In small offices (one to four doctors), there can be no fixed rule whether one specific aide should be designated as "office manager." The designation can have both positive and negative effects on office efficiency, depending on the personalities involved. As a general rule, therefore, a small office should refrain from naming any present aide as office manager until and unless she actually e*arns* the title by effectively assuming leadership duties.

This principle is particularly important if there are several senior aides working well together, perhaps interchanging duties as the needs arise, with neither person being the "boss." Many small offices function extremely well with no one aide in charge, for the aides often see the office as their joint responsibility. To name one person as the manager in such instances can destroy a good working environment.

Where one aide qualifies for the responsibility *and* the small office really needs a lay manager, the designation can be made. If an office has only two or three employees the office manager will of necessity have continuing office duties in addition to management. This simply places more responsibility upon her and establishes her as an intermediary between the physicians and the staff.

In larger or busier offices, an office manager is likely to be needed on a full time basis. Such a person might be a senior, trusted aide promoted to the job, or the position might be recruited from outside the office. There is, for example, a decided trend of practices as small as three doctors towards employing a full time manager (often male) from the business fields, contrary to seeking a person with prior experience as a medical office nurse, receptionist, or bookkeeper. At any rate, the manager in these situations should have as few normal office duties as possible, as his or her full time and attention can be devoted to making the office function well.

An office manager's success will depend in large part upon how the doctor or doctors regard the job. If the manager will continue to have normal office duties as well, care must be exercised that the doctors respect and retain her supervisory role; a doctor should deal with office problems through the manager and not by bypassing her. He should also recognize that effective management takes much of an aide's time and attention, so that lightening her routine work load can help her actually manage.

These principles of physician support grow even

stronger for the full time manager. That person must think and act as an "executive," which even means refraining from filling in on each routine task each time an aide is absent from work or a job is overtaxing the present staff. A former aide promoted to managership must particularly avoid this temptation to provide backup at every job, especially if she can probably handle it better than anyone else, for in her effort to fill each gap she will lose time and attention for the important aspects of managing the whole office.

Doctors are sometimes skeptical that managing a moderate size office (perhaps three to six doctors) is really a full time job. Furthermore, the sight of a manager performing no visible specific tasks tends to annoy overly busy physicians and staff. One old adage might, however, be kept in mind: The better the office is functioning, the less the manager seems to be doing; and the busier the manager, the less effective is the office.

It is essential, however, to enter any office manager relationship with a sound understanding of what he or she is expected to do. This calls for a written job description prepared either by the doctor or doctors or by the manager for review and approval. One such fairly brief "Possible Job Description for Office Manager" appears at the end of this article.

Job assignments

Medical offices are routinely more efficient if each aide has specific duties to perform. This is so even though smaller practices obviously require a degree of crossing between jobs because of vacations, sick leaves, lunch breaks and the like. Thus, even if aides must perform other tasks from time to time, they still should have primary responsibilities.

A very basic reason for this emphasis on specialization is that it fastens an aide's accountability to the office manager or to the doctor for matters within her area. As just one example, if the receptionist has been encouraged to collect fees promptly as patients leave an office visit, records can be kept as to her success from month to month. When a variety of aides tends the reception desk, however, one cannot "pressure" anyone for improving results.

A corollary to accountability is pride in one's job. This is clearly easier to instill if the employee's job is individualized so that credit or criticism can be given to the right person.

As in other aspects of personnel management, some physician time and attention is necessary to create specialized job assignments. Written "job descriptions" must be made up for each aide, with the doctor either doing that work himself or reviewing and approving drafts prepared by his senior aide or office manager. A job description should specify each duty for which the aide has primary responsibility, for which she is held directly accountable; and it must also describe all those tasks for which she must be secondarily responsible when the primary person is absent or becomes overloaded.

The finally approved "job descriptions" should be handed to each aide for continuing reference. Complete copies of the descriptions should also be retained by the doctor and by the office manager, if there is one. In addition to continuing reference, these descriptions will prove invaluable for discussion of an aide's performance when she is being evaluated for a salary raise. The descriptions will also serve as a good base for some office staff meetings, at which possible changes in job assignments for improved efficiency will occasionally be discussed.

XYZ MEDICAL CLINIC
Possible Job Description for Office Manager

1. **Financial**
   a. Preparation of proposed annual budget
   b. Approval of all expenditures
   c. Preparation or review, and analysis, of monthly statements
   d. All special financial studies, reports, etc., requested
   e. Liaison with accountants

2. **Personnel**
   a. Recruiting, hiring and firing
   b. Supervision, including salary review and proposed adjustments
   c. Maintain control and records of vacations, sick leave, etc.
   d. Organize regular office meetings and set agendas
   e. Determine and change personnel assignments and job descriptions as needed.

3. **Supplies**
   a. Order all supplies (medical and clerical)
   b. Maintain supply records, pricing studies, etc.

4. **Professional Corporation**
   a. Monitoring of fringe benefit programs
   b. Supervision of pension and profit sharing funds (as liaison between advisors and doctors)
   c. Coordination with attorney and accountant on corporate details

5. **Collections**
   a. Supervise systems for delinquent account followup
   b. Handle difficult collection matters

6. **Audit Controls**
   a. Review and supervise internal systems for handling cash, recording mail receipts, writing checks, etc.
   b. Followup on audit control systems devised by accounts

7. **Insurance**
   a. Handle and recommend all office and corporate insurance coverages

8. **Office Facilities**
   a. Assure proper maintenance of present office; order new equipment; obtain supplies and services.
   b. Be responsible for all aspects of office maintenance and coordination with landlord
   c. Investigate and act as agent for doctors in office building ownership, development of plans for office changes, etc.

9. **Personal for Doctors**
   a. Act as business agent for doctors personally in all areas where their time can be saved for medical work.
   b. Carry out assignments for doctors as may be required of their civic, medical or other committee positions.

GLYCOTUSS.™

(guaifenesin)

it frees coughs by removing their cause.

GLYCOTUSS (guaifenesin) is the effective expectorant that works to manage the common dry cough.

Glycotuss (guaifenesin) is long acting and efficient in a large percentage of coughs, particularly the familiar dry, non-productive cough. Its action is to remove the cause of the cough rather than to just smother it temporarily. In addition, Glycotuss does not cause the undesirable side effects, such as gastric distress, common with other guaiacols.

Glycotuss increases the secretions of the bronchial tree. Following medication, fluids in the respiratory tract are enhanced with less mucus and reduced viscosity. The increased flow of less viscid secretions exerts a demulcent effect on the tracheo-bronchial mucosa, promotes ciliary action and facilitates removal of inspissated mucus.

Indications: GLYCOTUSS (guaifenesin) is of value in the treatment of coughs particularly the unproductive cough due to the common cold

In chronic bronchitis and bronchiectasis it apparently aids healing in the chronic stage of inflammation by causing irritation. The sputum often decreases in amount and is less objectionable in taste and odor

Dosage: Adults: One or two tablets or teaspoonfuls every four hours. The suggested adult maximum daily dosage is 800 mg. unless directed otherwise by the physician. Children (6 to 12 years): one tablet or teaspoonful every four hours. Children under 6 years as the physician directs

Contraindications: Contraindicated in patients who have a history of sensitivity to guaiacol

Side Effects: No serious side effects have been reported of guaifenesin. Occasional gastric disturbance and nausea have been encountered

Supplied: GLYCOTUSS (guaifenesin) is available as tablets in bottles of 100, 500 and 1,000, as a pleasantly flavored syrup, in pints and gallons

Each tablet contains 100 mg. guaifenesin. Each teaspoonful (5 ml.) contains 100 mg. guaifenesin

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Opinion & Dialogue

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration

The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

n purpose of drug information
he patient is to get his coopera-
in following a drug regimen.

paration and distribution of ent drug information

We would hope to amass infor-
ion from physicians, medical
eties, the pharmaceutical indus-
nd centers of medical learning.
ultimate responsibility for uni-
n labeling must, however, rest
the Food and Drug Administra-
. There is nothing wrong with
agency saying, "this informa-
is generally agreed upon and
efore it should be used," as long
ur process for getting the infor-
ion is sound.

Distribution of the information
problem. In great measure it
ld depend on the medication in
stion. For example, in the case
n injectable long-acting proges-
ne, we would think it mandatory
sue two separate leaflets—a
t one for the patient to read be-
getting the first shot and a long
to take home in order to make a
sion about continuing therapy.
is case, the information might
ut directly on the package and
removable at all. But for a medi-
on like an antihistamine this
rmation might be issued sepa-
ly, thus giving the physician the
on of distribution. This could
erve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

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r the doctor can remove that fear
0 or 30 minutes of conversation.

I'm not suggesting that we
hold any information from the
ent because, first of all, it would
otally dishonest and secondly, it
ld defeat the very purpose of the
rt. I do think that a patient on the
n control pill should know about
ncidence of phlebothrombosis.

If you're going to tell a patient
ncidence of serious adverse re-
ons, then you have to tell him
a concerned medical decision
made to use a particular medi-
on in his situation after careful
sideration of the incidence of
plications or side effects.

tionally unstable patients pose ecial problem

There are patients who, be-
e of severe emotional problems,
d not handle the information
ained in a patient package in-
Yet if we are going to have a
kage insert at all, we just can't
two inserts. I think we might
ly have to tell the families of
e patients to remove the insert
the package.

l implications of the patient kage insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

Dr. Masland addresses House of Delegates

'Ladies and Gentlemen, we are being regulated to death. Right now a virtual army of federal regulators, some 63,000 strong, is costing us $130 billion a year. That comes out to a cost of $2,000 for each American family. In the field of health, safety, and products regulations, it is costing us more than $10 billion . . .

Nowhere can we find a better example of government by regulation than in medicine . . . And in my hand, I hold the whip—the *Federal Register*. Through its tiny print and legal gobbledygook, it does things to us that no senator or congressman would have the guts to do. It is written by people who do not run for office and are not accountable to the public. The *Federal Register* is a code book written by government lawyers designed to accomplish the intent of the regulators while confusing and turning off the regulatees.'

History and tradition mean a great deal to me. My becoming a doctor continues a tradition going back eight generations in my family. Up until this time just being a doctor has been my greatest satisfaction. But today as I think about the year ahead and the responsibilities of the office of president of this great Society and the honor that it carries with it, I am filled with pride and humility. Except for the joys of my family, it is the greatest event in my life.

I follow one of the strongest presidents the Society has ever known, Dr. Ray Crane. What a test this malpractice crisis has been. Ray, we salute you for the bold, articulate leadership you have provided during this year of crisis.

As most of you know, I come from a small county society, Cumberland County. Just to the east of Carlisle, our county seat where I practice, is a modest suburb better known as Harrisburg. In looking back through our history I find that I am the second member of the Cumberland County Medical Society to become president of PMS, the first being Dr. S. B. Kieffer, back in 1874. In honor of that occasion, the 24th Annual Meeting of the Medical Society of the State of Pennsylvania was held June 11 and 12 in Carlisle. The business meetings were held in the Cumberland County Court House. It was at that meeting that Dr. R. L. Sibbert from Cumberland County introduced a resolution calling on the Legislature to pass an act prohibiting the practice of medicine and surgery in Pennsylvania by persons not graduated from some legally authorized medical institution. This resolution eventually led to the Medical Registration Act of 1883.

I know that Ray has reported to us on the malpractice situation, but I want to say a few words about it in terms of the coming year. Now it is time to draw our plan for 1976 and after. We must tell the legislators, in no uncertain terms, that they have still not solved the malpractice problem, and that they will not solve it until they make the major reforms in the tort system we have urged. We are not going to give up on these reforms.

In the meantime, there are actions that we as a Society can and must take. The patient contract which this House authorized at its Special Session must be brought to fruition. Meetings have been held with the Hospital Association and we have gone through several drafts. This work must continue and the voluntary arbitration form perfected and implemented. Patients want to know what the rules are. Experience elsewhere in the country shows that binding arbitration works. The public is ready to do what the trial bar is not. We must take the lead and show that doctors and patients can sit down together and agree on the ground rules for treatment and expected results and establish mutually acceptable techniques for settling grievances which are not mutually destructive. **I recommend that this House reaffirm its support of the patient contract and its early implementation.**

In the past we have heard a lot about the "conspiracy of silence." Today I'm increasingly concerned about the "conspiracy of settlement." By this I mean the increasing desire of insurance companies to settle questionable cases. Every non-meritorious case that is settled simply feeds the fires. We must draw the line and stop this extortion. Now I recognize that I am asking some doctor, sometime, somewhere in this state to put his career on the line, but unless we have the guts to stand up and fight for our own rights, then we can't expect others to do it for us.

I recommend that we develop a medical defense unit within the Society sufficiently financed to field a legal defense team second to none. The team would defend all doctors. I believe that it would take only one or two test cases for the message to get out to every plaintiff's attor-

ney in the Commonwealth that we are no longer going to cave in on these non-meritorious suits. I recognize that this proposal involves some technical problems and requires coordination with the carriers. Nevertheless, I strongly recommend its approval.

You will recall that at the Special Session this summer you authorized us to finance countersuit, where we could find a promising case. We are doing this and I feel confident that the first suit will be filed during my term of office.

As we daily worked with Pennsylvania's malpractice crisis, we read the newspaper accounts of the struggle in California, New York, Michigan, Florida, Texas, and elsewhere. The headline for many of these stories was "strike," and indeed we came very close to crossing that Rubicon ourselves. Our flirtation with union tactics has caused me to reexamine my own thoughts on physicians' unions.

I believe organized medicine can do anything that a physician's union can do and do it better. But I am afraid that there are some physicians who feel that the name union implies some greater degree of power. The only seeming advantage that a union might have is its ability to strike. But the real question we must answer is whether we would be willing to strike, no matter what the name of the organization. In my experience, physicians are very independent. They are by nature and training used to making up their own minds. I do not believe that joining a union would guarantee that when ordered to, physicians would go out on strike.

At the same time, I am not saying that under no circumstances should physicians ever strike. There may come a time when there is absolutely no other avenue left. At that time, physicians may determine to slow down, or strike, or whatever, but it will not be because of the organization to which they belong, but because of the conditions under which they are being forced to practice. I would, therefore, urge doctors to think very carefully before joining a physician's union. If in their hearts they believe they will always reserve for themselves the decision on whether or not to withhold or restrict services, they should rely on organized medicine to represent them.

Without unquestioned obedience to a strike call, there is nothing that a union can offer that is not already being done by your Society. By joining PaMPAC you have an opportunity to let your dollars work for you in the political arena just as they would if you were a member of a union pac. Your dues in the State Society support an aggressive professional lobbying operation far more experienced and effective than a physician's union could organize. Through the size and strength of the State Society we have been able to retain legal counsel of a stature and depth far beyond the capacity of a fledgling union. Finally, the breadth of the Society's activities in all other areas, such as continuing education, accreditation, emergency medicine, liaison with Blue Shield, practice management, and communications—all of these programs together and dozens of others result in a credibility for our organization far greater than that of any union. We are successful not because of any one element, but because of the combined strength of all these activities.

The House of Medicine is broad and has room for many elements. Within the Society we are able to embrace many groups ranging from the crisis committee to the 805 committee, from county societies to specialty societies.

By contrast, I believe the parallel existence of physicians' unions and organized medicine weakens both. I would prefer to see the members of physicians' unions use their energy constructively inside the framework of organized medicine.

While I am strongly opposed to a strike by physicians, responsible leadership calls for us to understand all the ramifications of such a drastic action. We must, therefore, study carefully the effects of a slowdown. Our Council on Education and Science has already prepared a plan for emergency services in a strike. We must now study the strikes in California and New York. We must work with the Hospital Association to formulate guidelines for strikes and establish mechanisms for communicating with and assisting hospital employees during a physician strike. In addition, we must begin to train physician negotiators and develop staff expertise for backup.

While I am convinced we do not need a union, at the same time I believe the Society should take all prudent actions to protect its members.

I wish I could tell you that we are over the hump, but such is not the case. 1976 will be full of critical issues. The regulation of physicians' office labs has moved to the front burner. The Society must take vigorous bold action here.

The new Health Planning and Resources Development Act of 1974 (P.L. 93-641) is setting the stage for National Health Insurance. It will be dominated by consumers. Here in the Commonwealth the Shapp Administration is pushing hard to control hospitals and eventually physicians with its Comprehensive Health Legislation, House Bill 853 and Senate Bill 10. We are opposed to these bills in their present form and have so testified. I can foresee a communications program similar to that of 805 to block this takeover by the Health Department.

Government's mad rush into generics must be tempered. Our Commission on Therapeutics has already testified on generic legislation and we will continue to respond vigorously. The generic issue arises at both the state and federal level. I wish to keep an open mind on generics. I believe the test must be the welfare of our patients. If I am personally satisfied that a particular generic will do the job, my patient and I should have that option.

I recognize that the medicare and medicaid programs

and their PSRO bandaid are developing acute atherosclerosis. The money that the government is allegedly saving through new restrictive medicare regulations will eventually be paid by aged Americans out of their shrinking incomes and savings, all because Congress has been unable to realistically deal with inflation. Because the federal government is copping out on its own programs we will see a return to the two-tier pricing system in medicine. In order to accept medicare and medicaid fees more and more physicians will increase their prevailing charges to other types of patients in order to subsidize the below cost returns of failing government programs.

My recent experience of testifying in Washington before the House Subcommittee on Health has convinced me of our need, as a state organization, to stay alert to what's happening in Washington. On the subject of National Health Insurance I believe we must seek legislation which protects individuals against catastrophic illness and provides care for the medically indigent. At the same time we should fight all legislation which is broader than this. Certainly any National Health Insurance program should be administered by the private insurance industry.

It was during this hearing, at which medical authorities from England, Canada and Sweden testified, that I realized how lax we have been about opening medical records to government and other third parties. There is nothing more closely associated with the doctor-patient relationship than the confidentiality of the medical record. In your packet is a resolution dealing with this matter from my home county. It calls for legislation prohibiting the examination of any physician-patient record by any governmental or non-governmental agency without the signed permission of both the patient and the physician. Ladies and Gentlemen, the medical experts from abroad were appalled at the casual way in which sensitive medical information is made available to government bureaucrats and other persons. I think this matter needs urgent action.

I sense a growing disenchantment with government in general and the federal government in particular. The great social programs of the Johnson years have failed leaving a trail of broken promises and a swollen bureaucracy. What the average American has known for some time is just now being discovered in Washington. Caspar Weinberger, upon leaving as Secretary of HEW said, "My single overriding observation after all these years in Washington is the growing danger of an all pervasive federal government. Unless checked, that growth may take from us our most precious personal freedom. It also threatens to shatter the foundations of our economic system."

Ladies and Gentlemen, we are being regulated to death. Right now a virtual army of federal regulators, some 63,000 strong is costing us $130 billion a year. That comes out to a cost of $2,000 for each American family. In the field of health, safety, and products regulations, it is costing us more than $10 billion. I'm talking about the Interstate Commerce Commission, the Federal Power Commission, the Federal Communications Commission, the Securities and Exchange Commission, the Federal Maritime Commission, the Civil Aeronautics Board, the Environmental Protection Agency, the Occupational Safety and Health Administration, and the Consumer Product Safety Commission, just to name a few. Then there are the activities of the departments such as HEW with its Food and Drug Administration and its HSAs, HMOs, PSROs, etc.

Nowhere can we find a better example of government by regulation than in medicine. Here are just a few of the regulations which affect the way you and I practice medicine everyday. And in my hand, I hold the whip—the *Federal Register*. Through its tiny print and legal gobbledygook, it does things to us that no senator or congressman would have the guts to do. It is written by people who do not run for office and are not accountable to the public. The *Federal Register* is a code book written by government lawyers designed to accomplish the intent of the regulators while confusing and turning off the regulatees. Listen and I'll show you what I mean. Here's a selection from some medicare regulations published in the *Federal Register* last year:

> After the submission or appearance provided for in paragraph(c) of this section, or if none, after fifteen days from the date of mailing of the notice of proposed determination (or such other period as provided in paragraph (c) of this section), the Administration may make a determination under paragraph (b) of this section, or under Paragraph 405.614 (a) (5), as appropriate. Such a determination is an "initial determination" for purposes of the appeals procedures in Subpart O of this part (see Paragraph 405.1502 (e)).

All of us understand what is happening to us, but *why* is it happening and what can we do to stop it or at least slow it down? Remember the words of Allen Wallis, the chancellor of the University of Rochester in his commencement address.

He said that control of health care by lawyers would come about through the process of "turning to the government to solve all problems, real or imagined, large or small, widespread or confined . . ." There have been times when I personally believe we have been dangerously close to this kind of legislative overkill in this House of Delegates. We must guard against scattering our shots too broadly, and asking for a law to right every problem in sight. We should not use laws as a substitute for common sense. Sometimes, we need public education, rather than a law. When we go to the Legislature, it should be for priority items.

Many solutions lie not with one more law, but within ourselves. Bureaucrats come in where we are weak, where we have been unable or refused to take action to clear up a problem. I come from a small community and our health care establishment is small enough for me to know its strengths and weaknesses. And I admit, we have not done all that we could. At the medical staff level we could do a better job of credentialling and peer review. At the county medical society level we have responded to some grievances but we could do a better job.

The whole question of quality review is something we could have done on our own without PSRO interference.

Our public opinion survey on the malpractice issue revealed some very disturbing trends. There was a growing impression of doctors being preoccupied with their incomes and being less and less sensitive to their patients'

needs.

At times I get the impression that we are fighting for our standard of living rather than our way of life. We become more concerned about getting a dollar than about how we get it or from whom we get it. An example is the medicaid program. I think it's more important that the Welfare Department have Blue Shield administer the office portion of the medicaid program than it is to get a dollar more for a house call. Along this same line I believe that House Bill 853 and Senate Bill 10 will probably affect us much more profoundly in the future than House Bill 1367. The Comprehensive Health Bills regulate the institutions in which we spend most of our time, our community hospitals. Eventually every decision made therein will be subject to pre, concurrent, and post bureaucratic Monday morning quarterbacking.

While it may and I emphasize may be possible to legislate competency there is no way we can legislate compassion, love, or honesty. Ladies and Gentlemen, we are scientists by training and license, but we are physicians because of our attitudes and character and unless the idea of going into that office or hospital everyday to help people turns us on, we'd better not go in.

We need doctors who like people. And that message has got to come across in the doctor-patient relationship. Too many of us are turning off our patients. The communications people say, "The medium is the message." For example, ten people who get an individually typed and signed letter will respond better than ten people who get a form letter with a stamped signature, even though the words in the letters are the same.

My friends, we are the medium. The tone of our voice, our body language, whether we appear nervous or relaxed, whether we talk slowly or quickly, whether we move slow or fast, whether we look the patient in the eye, whether we smile—all of this tells the patient as much about his condition as the words we use.

I do not think there is a physician in Pennsylvania, who, if I asked him, wouldn't tell me that he gets along with his patients beautifully, yet many of us have great failings in this area. Three of us on the PMS Board, as part of an experimental program, were privileged to attend a week long leadership retreat. And do you know what we learned? We learned that we don't come across to our patients exactly as we think we do. We saw and heard ourselves through the eyes and ears of others and it was helpful.

Now you and I know that there are doctors who generate malpractice suits simply by what they say or don't say to their patients and the way they say it. Sure we all have difficult patients, but that's part of the job. We must learn to communicate successfully with them. In this whole malpractice crisis, we have leaned heavily on outsiders for solutions, notably state government. But I will not let us overlook the area of patient communications which is solely within our control. I believe we should investigate the development of courses, seminars, and other opportunities for medical students and practicing physicians to improve their patient communications skills and to better understand their own hangups.

As we move forward into the Bicentennial year, I am

optimistic about the things we can achieve. We have in PMS a viable organization with the resources to win. But it does require that each of us get involved.

Your assignment back home is to disseminate this spirit of enthusiasm and optimism. You must tell your colleagues that we have in the Pennsylvania Medical Society an organization upon which we can rely, an organization that can serve us well if we give it our full commitment and if we get involved locally. We have an organization with a staff second to none. They are respected by friend and foe alike and have increased their stature through many hours of hard work, particularly through this year of the malpractice crisis.

Your assignment is to plug your local people into the State Society. Pick a subject of interest and get someone from headquarters to come out and speak at a county society meeting or a medical staff meeting. Now I know that's hard but it can be done. Somehow you have to find the telephone number of the Society. Then you have to pick up the phone and dial the right number. You can even do this collect. But if you will take this extremely difficult step, I will personally guarantee that you will get satisfaction or your money back. Someone at the other end will help you. You will get a speaker and a good one. Your members will find out what PMS is doing about a subject of concern to them and they will find out what they can do. Together, we will have taken one small step forward.

Your assignment is to find out how you come across as a doctor. Suggest to your colleagues that this is an area to explore. Let's get something going on this patient communication thing.

Your assignment is to discuss the problems of medicine and to bring them to PMS, but when you do, come with a matching program. That is, don't lay it all on PMS. Tell us what your people are willing to do. Set your own house in order.

To summarize, in my judgment, we have or can acquire the expertise within the Pennsylvania Medical Society to meet any challenge you give us. All it requires is your strong support and local involvement. To the extent that we fail to make PMS work, our professional lives will be increasingly ruled by the anonymous bureaucrats who publish the *Federal Register* and the *Pennsylvania Bulletin*. When we work together as a team and get involved, we remain free to practice as our training and experience tells us in this, the greatest and noblest of professions—medicine.

Continuing education...

HOME STUDY COURSES

(Each is acceptable for Category I continuing medical education credit toward the Physician's Recognition Award of the AMA.)

ANESTHESIOLOGY

Self-Evaluation Prgm (S)
Fee: $25 mbrs; $50 nonmbrs. Date: All yr.
Contact: Amer. Soc. of Anesthesiologists, 515 Busse Hwy., Park Ridge, Ill. 60068.

ANATOMY

Anatomy of the Peripheral Nervous System and/or Cardiovascular System (B)
Dates: Arranged; 100 hrs. instruction
Contact: Univ. of Iowa Coll. of Med., Newton Rd., Iowa City, Iowa 52242.

CARDIOVASCULAR DISEASE

Amer. Coll. of Cardiology Extended Learning (B)
Fee: $70 mbrs; $80 nonmbrs.
Date: Arranged; 12 hrs. instruction

Supplemental Program 1 - Vectorcardiography (B)
Fee: $12.50 subscribers, ACCEL™; $14.50 nonsubscribers
Date: Arranged; 1 hr. instruction

Supplemental Program 2 - Familial Hyperlipoproteinemias (B)
Fee: $12 subscribers; $14 nonsubscribers
Date: Arranged; 45 mins. instruction

Supplemental Program 3 - Phys. Self-Assessment (B)
Fee: $16.50 subscribers; $18.50 nonsubscribers
Date: Arranged; 1 hr. instruction

Supplemental Program 4 - Paul Dudley White, M.D.: A Memoir (B)
Fee: $14 subscribers; $16 nonsubscribers
Date: Arranged; 30 mins. instruction

Supplemental Program 5 - Digitalis I (B)
Fee: $13 subscribers; $15 nonsubscribers
Date: Arranged; 40 mins. instruction

Supplemental Program 6 - Digitalis II, Clin. Pharmacology of Digoxin (B)
Fee: $16.50 subscribers; $18.50 nonsubscribers
Date: Arranged; 40 mins. instruction

Supplemental Program 7 - Cardiomyopathies (B)
Fee: $6 subscribers; $8 nonsubscribers
Date: Arranged; 40 mins. instruction

Supplemental Program 8 - Bundle of His Electrograms & the Analysis of Arrhythmias (B)
Fee: $17.50 subscribers; $19.50 nonsubscribers
Date: Arranged; 45 mins. instruction

Supplemental Program 9 - Acupuncture Anesthesia (B)
Fee: $16.50 subscribers; $18.50 nonsubscribers
Date: Arranged; 45 mins. instruction

Supplemental Program 10 - Congenital Heart Disease in Infancy (B)
Fee: $7 subscribers; $9 nonsubscribers
Date: Arranged; 1½ hrs. instruction

Supplemental Program 11 - Heart Sounds & Auscultation (B)
Fee: $9 subscribers; $11 nonsubscribers
Date: Arranged; 50 mins. instruction

Supplemental Program 12 - Evaluation of Ventricular Function of Coronary Artery Disease by Noninvasive Methods (B)
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Date: Arranged; 40 mins. instruction

Supplemental Program 13 - Regulation of the Circulation
Fee: $17.50 subscribers; $19.50 nonsubscribers
Date: Arranged; 1 hr. instruction

Supplemental Program 14 - Ultrastructure & Biochemistry of the Myocardium (B)
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Supplemental Program 15 - Exercise, Physical Fitness & the Heart (B)
Fee: $17.50 subscribers; $19.50 nonsubscribers
Date: Arranged; 1 hr. instruction

Supplemental Program 16 - Echocardiography (B)
Fee: $19 subscribers; $21 nonsubscribers
Date: Arranged; 1 hr. instruction

Supplemental Program 17 - Drug Interaction (B)
Fee: $7 subscribers; $9 nonsubscribers
Date: Arranged; 50 mins. instruction

Supplemental Program 18 - What Herman Hellerstein Tells His Patients About Exercise, Diet & Sex After a Myocardial Infarction (B)
Fee: $7 subscribers; $9 nonsubscribers
Date: Arranged; 1 hr. instruction

Supplemental Program 19 - Conversations in the Coronary Care Unit (B)
Fee: $8 subscribers; $10 nonsubscribers
Date: Arranged; 1 hr. instruction

Supplemental Program 20 - A View of Angina Pectoris From the United Kingdom by Walter Somerville (B)
Fee: $7 subscribers; $9 nonsubscribers
Date: Arranged; 30 mins. instruction

Supplemental Program 21 - Current Concepts of Hypertension (B)
Fee: $8 subscribers; $10 nonsubscribers
Date: Arranged; 55 mins. instruction

Supplemental Program 22 - Thrombophlebitis: Detection, Prevention, Treatment (B)
Fee: $14 subscribers; $16 nonsubscribers
Date: Arranged; 30 mins. instruction

(Continued on page 72.)

KEY (G) for General Practitioners (S) for Specialists (B) for both

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See reverse side for full prescribing information

Choloxin® (sodium dextrothyroxine)

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Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules
See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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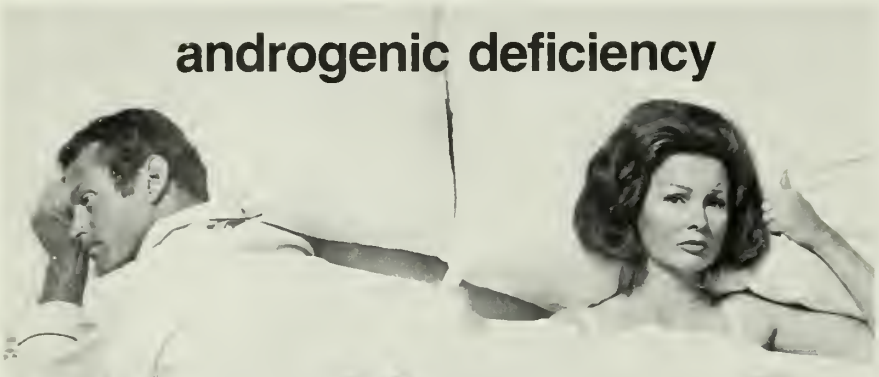
Deerfield, Illinois 60015

When **impotence** due to

androgenic deficiency



is driving them apart

Android®-5 MUQETS BUCCAL Tabs

Android®-10 ORAL Tabs

Android®-25 ORAL Tabs

Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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L-lysine	100 mg
Nicotinic Acid	12.5 mg
Iron (from Ferrous Sulfate)	2.82 mg
Vitamin A	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg
Riboflavin	2.5 mg
Ascorbic Acid	25.0 mg
Folic Acid	0.1 mg
Vitamin B-12	1.5 mcg
Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide	0.075 mg
Calcium (from Dicalcium Phosphate	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 mg
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg

ACTION AND USES — DOSAGE: 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets. Rx only.

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1 TITLE OF PUBLICATION: Pennsylvania Medicine	2 DATE OF FILING: October 1, 1975
FREQUENCY OF ISSUE: Monthly	3A. ANNUAL SUBSCRIPTION PRICE: $5.00

3 LOCATION OF KNOWN OFFICE OF PUBLICATION (Street, city, county, state and ZIP code) (Not printers): 20 Erford Road, Lemoyne, PA 17043

4 LOCATION OF THE HEADQUARTERS OR GENERAL BUSINESS OFFICES OF THE PUBLISHERS (Not printers): 20 Erford Road, Lemoyne, PA 17043

5 NAMES AND ADDRESSES OF PUBLISHER, EDITOR, AND MANAGING EDITOR

PUBLISHER (Name and address): Pennsylvania Medical Society, 20 Erford Road, Lemoyne, PA 17043

EDITOR (Name and address): Dr. David A. Smith, 20 Erford Road, Lemoyne, PA 17043

MANAGING EDITOR (Name and address): Mary L. Uehlein, 20 Erford Road, Lemoyne, PA 17043

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Emergency in Pennsylvania — a status report

I am pleased to introduce this important issue of PENNSYLVANIA MEDICINE. *In June of this year, the Pennsylvania Emergency Health Services Council, in cooperation with the Division of Emergency Health Services, Pennsylvania Department of Health, presented to Governor Milton J. Shapp the* Comprehensive Emergency Medical Services Plan of Pennsylvania. *The plan calls for a coordinated attack by government, voluntary organizations, and professional associations on the deficiencies in emergency health care delivery in the Commonwealth.*

The Pennsylvania Medical Society has been in the forefront in directing public and professional concern to the provision of emergency health care, as demonstrated by its publication, Emergency Medical and Health Services in Pennsylvania, *and its Commission on Emergency Medical Services. The Society is vitally concerned in the delivery of quality emergency medical care to every citizen and visitor to Pennsylvania.*

I urge each of my colleagues, as they review this issue, to carefully consider and then to become involved in closing the great gap between onset of sudden illness or trauma, recognition, and the effective delivery of emergency medical care.

Leonard Bachman, M.D.
Secretary of Health
Commonwealth of Pennsylvania

What's wrong with emergency services in Pennsylvania?

H. ARNOLD MULLER, M.D.
Hershey

In order to understand what is wrong with emergency medical services in Pennsylvania, it is necessary to conceptualize an ideal system in which everything is "right."

In the "ideal" emergency medical or health services system, the public has been educated to recognize a medical emergency and trained to immediately implement life support measures while simultaneously calling for help. Communication is effected with a central emergency operations center dispatcher by dialing the universal emergency telephone number 911. The trained dispatcher correctly interprets the call for help, advises the caller of measures to take while awaiting further aid, and dispatches appropriate and trained ambulance personnel as well as any other needed emergency personnel and equipment.

Responding emergency medical personnel relieve the public of their life support endeavors, stabilize the patient's condition, notify the appropriate medical facility of the event, and request any necessary instructions. After adequate preparation, the patient is transported to an appropriate medical facility with due care for the safety of patient, emergency personnel, other drivers, and pedestrians. Emphasis is placed on medical treatment rather than speed.

The receiving facility is notified that a mobile emergency unit is en route, the number of patients and nature of their problems, including their vital signs and expected time of arrival. The receiving medical facility which may or may not be monitoring the patient's biological functions by telemetry is thus given time to prepare for the anticipated patient and his or her particular medical problem(s). The receiving facility is one in which personnel and equipment are capable of further basic and definite life support. The patient is either admitted to that facility's inpatient service or, following stabilization of the medical condition, is transferred to a facility with appropriate long range capability including rehabilitation for that patient's problem(s). Appropriate data is collected on all patients so that an evaluation of the emergency medical services system may be carried out and research studies initiated where indicated.

The author is aware of no geopolitical area in Pennsylvania in which all elements of such an "ideal" emergency medical services system have been *totally* perfected and implemented.

There have been too few programs aimed at creating public awareness of emergency medical or health services. Most Pennsylvanians neither recognize their responsibility for aiding the development of an emergency medical services system nor understand the need for personal education and training which would enable them to recognize emergency medical problems and initiate appropriate life support measures. Many adults do not realize that ten year old children can give effective mouth to mouth ventilation and thirteen year olds effective cardiac compression. Physicians recognize that we cannot hope to achieve the salvage of life and limb known to be possible with the knowledge and techniques available to us today unless the public is taught to immediately initiate life support measures, such as cardiopulmonary resuscitation, control of external hemorrhage, relief of upper airway obstruction, or treatment of shock.

It is estimated that there are twenty thousand ambulance attendants in Pennsylvania. The Commonwealth, however, does not require any emergency medical care training of ambulance personnel, not even rudimentary first aid. Yet barbers are required to take hundreds of hours of training before one's hair may be entrusted to them without supervision!

To date about 7,700 ambulance attendants in Pennsylvania have been

Dr. Muller served as medical advisor for this special issue on emergency health services. He is medical director of the Division of Emergency Health Services, Pennsylvania Department of Health, chief of the Division of Emergency Medicine at The Milton S. Hershey Medical Center, and president elect of the Pennsylvania Chapter of the American College of Physicians.

Use of Intramuscular Injection in Suspected Myocardial Infarction

When a patient is admitted to the emergency department with chest pain which is suspected to be a myocardial infarction, it is unwise to use any intramuscular injections. Enzyme, CPK, is found in myocardial and skeletal muscle. Usually, CPK is elevated with an acute myocardial infarction. However, since it is also found in skeletal muscle, it can be also elevated in the serum if intramuscular injections are given. This can lend to confusion in the diagnosis of acute myocardial infarction. Because of this we recommend that intramuscular injections not be used in patients who are suspected of having acute myocardial infarctions. Of course intravenous injections may be given under these circumstances.

David M. Leaman, M.D.
Assistant Professor Medicine
Division of Cardiology
Hershey

Use of Atropine in Acute Myocardial Infarction

It has been customary to use intravenous atropine to increase the heart rate in patients who have sinus bradycardia and acute myocardial infarction. Recent studies strongly suggest that the use of atropine in the patient with acute myocardial infarction will decrease the ventricular fibrillation threshold. Because of this, we do not recommend the use of atropine to increase the sinus rate in this situation. If premature ventricular contractions are present, they should be treated with the standard method, using intravenous lidocaine rather than trying to overdrive them by using atropine and producing sinus tachycardia.

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certified as Emergency Medical Technicians - Ambulance. People so certified have taken and passed written and skill examinations after completing an 81 hour course developed specifically for ambulance personnel by the U.S. Department of Transportation. But what of the other 12,000 ambulance personnel? Depending on the area of Pennsylvania, 3 to 5 percent of ambulance attendants have had *no* training whatsoever![1]

Not infrequently in extrahospital emergency situations there is need for intravenous infusions and/or medications, endotracheal or nasotracheal intubation and/or defibrillation. Very few ambulance personnel have been trained in such skills.

Firefighters and police officers are often first at the scene of an accident or illness (first responders). Yet many have had little if any training in emergency medical care. Even in instances where a police officer or firefighter has such training, he may see his primary duty to be law enforcement or fire fighting despite the absence of medical personnel and the evident need for emergency medical care.

At present, dispatchers in emergency operations centers are usually not specifically trained in emergency medical care. Thus, inadequate advice to callers and inappropriate assessment of medical problems and therefore failure to initiate a proper response may at times result.

Judging by a recent study conducted in Southeastern Pennsylvania, a high percentage of nursing schools do not teach emergency nursing as part of their formal curricula.[2] Many hospitals do not require postgraduate emergency nursing care instruction of nurse applicants for emergency department positions. Emergency department nurses in some instances now find themselves less well trained, in terms of certain life support skills, than ambulance attendants who have been trained to the so-called Emergency Medical Technician-Advanced (Paramedic) level.

Few physicians have received formal training in emergency medicine, either as medical students or in their postgraduate years. Many of the nation's medical schools have not yet implemented emergency medicine courses in their curricula. There are only 32 residency programs in emergency medicine in the United States. While postgraduate courses for "so-called" second career physicians are now being given in different areas of the nation, the need of this heterogeneous physician group for selective training in emergency medicine topics and skills has not yet been met.

Pennsylvania as a whole has no "single" emergency telephone number nor do "pay stations" universally make provision for "coinless" emergency calls. A citizen of or visitor to Pennsylvania must frequently sift through a telephone directory to identify the suitable emergency number for this problem. Applying a label bearing an emergency telephone number to private or public phones is considered by the Courts as defacement of private property (owned by the phone companies.)[3] Legislation is needed to create a law allowing for the application of such labels.

All too often ambulances lack two-way radios which would allow them to communicate with a central operations center as well as hospitals. Such ambulances cannot request medical information or instructions, nor can they notify a facility of the number of ambulance patients, their physical status, or the ambulance's expected time of arrival at a medical facility.

There are no specifications for ambulance design. Curiously, there are laws and regulations which govern, to some extent, the use of siren and lights, but none which require specific life saving equipment, or as previously noted, emergency medical care training of ambulance personnel.

Though a given hospital may profess to have an emergency department, it need not remain open 24 hours a day seven days a week.

There are no Federal or Commonwealth standards relative to emergency department equipment, personnel coverage, or capability. There is no Commonwealth provision for the classification of hospital emergency departments which would aid paramedical or medical personnel in making a selection based on presumed medical need. Even more importantly, as previously noted, there is no requirement that a hospital with an emergency department be able to provide advanced life support and, if indicated, subsequent admission or transfer to another hospital with the necessary capability for continued patient care including rehabilitation.

You are invited to read the subsequent articles in order to appreciate what steps have been, are being, and will be taken to correct this less than optimum state of affairs of the various elements of emergency medical services. Only when such services are fully developed and effectively coordinated can we say the Commonwealth of Pennsylvania has an Emergency Health Services System. □

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Pennsylvania Department of Health

The division of emergency health services

H. ARNOLD MULLER, M.D.
Hershey

Created in 1969 and restructured in 1972, this small division (8 fulltime employees) has responsibility for the development of emergency health services for twelve million Pennsylvanians as well as those citizens of other states and countries who travel to or through the Commonwealth.

With such a charge, but limited personnel and budget, it was decided in 1972 that the division would concentrate its resources on four specific endeavors: (1) development of county or regional emergency health service councils, (2) development of appropriate emergency health services legislation, (3) development of institutes for training ambulance personnel to the Emergency Medical Technician-Ambulance level and (4) development of emergency health service personnel training and certification standards.

Fourteen emergency health service councils are responsible for 54 counties in which reside 86 percent of Pennsylvania's population. Thirteen of the councils are supported with funds from the U.S. Department of Transportation. One council (Lancaster) is not supported by Federal funds.

Council staff personnel work with *volunteer* council members who represent various groups and organizations interested and active in emergency health services—ambulance and fire services, hospitals, physicians, local government, nurses, American National Red Cross, American Heart Association, Pennsylvania Affiliate and its chapters, police, communication personnel, etc. Councils identify deficiencies in their emergency health services system areas and develop plans calculated to correct those deficiencies. Care is taken to coordinate county or regional activities with those of surrounding councils and with the Commonwealth. This "grassroots" approach has been very productive in terms of local, county, and regional emergency health services accomplishments. This approach places the responsibility for emergency health services with the local provider and consumer rather than with a "far away bureaucracy."

Although the Division of Emergency Health Services has either written or assisted in the writing of numerous bills designed to improve emergency health services in the Commonwealth, no significant emergency health services legislation has been enacted in the Commonwealth in the last several years. Recently (June 1975) Governor Milton J. Shapp emphasized the need for action by requesting that an emergency medical services legislative package be introduced by the fall of 1975.

Currently, there are four significant emergency medical services bills before the General Assembly. These bills pertain to: ambulance licensure, design, and equipment standards; legal recognition of the various levels of emergency medical technician training and capability; emergency medical technician certification and recertification; revision of the Good Samaritan Act affording protection to the public as well as to emergency health services providers; and a bill to control emergency medical vehicle operation (vehicles would be required to stop at red stop signals and stop signs). Improvement of patient care as well as safety of the patient and emergency health services personnel dictates that these bills be enacted into law.

There are 29 institutes in Pennsylvania designed to provide training for present and prospective ambulance personnel. The goal is to develop sufficient training institutes at various sites so that no individual desirous of receiving emergency medical technician training must travel more than twenty miles to attend class. As noted in the prior article, educational units have been responsible for the training of more than 7,700 Pennsylvanians to the Emergency Medical-Technician-Ambulance level. The basic training program for Emergency Medical Technician-Ambulance (81 hours) includes both didactic material and skill instruction in such aspects of emergency medical care as cardiopulmonary resuscitation, bandaging and splinting, recognition and treatment of pediatric, medical, and surgical acute illnesses and injuries and the proper care and use of the ambulance vehicle and its equipment, including extrication techniques. It is anticipated that at least 5,000 ambulance personnel will be trained to the Emergency Medical Technician-Ambulance level annually. At this time, recertification training courses are being initiated for those ambulance personnel who were certified as Emergency Medical Technicians-Ambulance 3 years ago.

Finally, personnel of the Division of Emergency Health Services continue to develop and review new examinations to complement the training and certification standards established at local, state, and federal levels. In addition, various emergency health services data collection, organizational and utilization systems are being studied.

The division will place subsequent emphasis on those areas of emergency health services deficiencies noted in my preceding article and to be addressed more fully in following articles.

Next, Roger S. Hunt writes of the Pennsylvania Emergency Health Services Council structure and of its activities since its formation in April 1974. The Division of Emergency Health Services and the Pennsylvania Emergency Health Services Council work "hand in glove," the latter organization serving as the advisory body to the Pennsylvania Department of Health on emergency health service matters. □

Pennsylvania emergency health service council

ROGER S. HUNT, M.B.A.

Philadelphia

There is now a central forum for the coordination and development of emergency health systems and services in the Commonwealth of Pennsylvania. The Pennsylvania Emergency Health Service Council was developed in 1974 as a voluntary organization to promote the development of emergency medical services in the Commonwealth, to aid and advise member organizations, and serve to coordinate their activities in emergency health at the state level. The council also serves as an advisory body to the Secretary of Health and the Division of Emergency Health Services as well as the State's Comprehensive Health Planning Agency. By acting in these capacities, the council serves to assure the input and involvement of professional and provider associations with planning and programming conducted by state agencies.

In an earlier article, Dr. Muller described deficiencies in emergency care which must be corrected before we may properly advance to "an emergency medical system" in Pennsylvania. A number of local, regional, and state associations had been working for years with sporadic success at coordinating improvement of various aspects of emergency health care delivery. In June 1971 the Pennsylvania Medical Society published a "white paper" on emergency medical services citing the deficiencies in emergency care statewide and calling for a unified and coordinated approach to these problems at the state level.

The devastation by the flood which ravaged Wilkes-Barre and communities along the Susquehanna River valley in June 1972 provided a grim demonstration of the need for a strong state and regional emergency system that could anticipate the needs of managing individual trauma on a daily basis as well as mass casualties resulting from an area-wide disaster. A system designed to be activated only upon the onset of major disaster could not be significantly effective unless it was developed as an extension of the people and systems providing emergency care on a daily basis.

At the same time, new county and regional emergency health services councils were being developed in different regions throughout the Commonwealth. As these councils began assessing needs and planning systems for their individual areas, it was realized that a new state plan would be needed to aid in coordinating and guiding these council activities. The Division of Emergency Health Services of the Pennsylvania Department of Health had limited staff and budget to provide this coordination and it was recognized that a new state plan could not be developed without the involvement of the major professional and provider organizations in the state.

In April 1974, Dr. Leonard Bachman, then the Governor's director of health services, invited representatives of agencies and organizations throughout the state to attend a meeting at Hershey Medical Center to discuss the formation of a "United Emergency Health Service Organization." Attending the conference were representatives of hospitals, medical schools, emergency councils, Comprehensive Health Planning Councils, ambulance and rescue associations, along with representatives of the Pennsylvania Medical Society, Hospital Association of Pennsylvania, Pennsylvania Ambulance Association, American College of Surgeons, and others. The meeting concluded with adoption of a resolution to appoint a steering committee to develop a new state organization for Emergency Health Services.

By the end of April, a 22 member steering committee had been formed as well as seven task forces to develop plans in the areas of public education, professional training, communication, facilities, transportation, and evaluation. While each of these areas had been reviewed before by different organizations in the Commonwealth, the steering committee provided a new forum where issues could be discussed and reexamined together by all concerned and involved parties.

By December, the original group of representatives that had met in April had reconvened to review the progress of the steering committee and task forces and to adopt bylaws for the new organization. Richard Evans, M.D., president of the Pennsylvania Chapter of the American College of Emergency Physicians, was elected as the first chairman of the Pennsylvania Emergency Health Service Council and a resolution was adopted to work with the Division of Emergency Health Services in writing a new Comprehensive E.M.S. Plan for Pennsylvania.

A membership structure was adopted for the council to provide representation of organizations involved with the coordination, planning or delivery of emergency health services on a statewide or broad regional basis. It was decided that this new council could be most effective in coordinating existing agencies and state associations who already had established memberships rather than attempting the creation of a new parallel organization. Thus, the activities of the state council would serve to enhance and coordinate such groups

The author is vice chairman of the Pennsylvania Emergency Health Service Council and vice president and administrator of Hahnemann Medical College and Hospital.

as the E.M.S. committees of the Pennsylvania Medical Society and the Hospital Association of Pennsylvania without duplicating effort and representation. In addition to that provided by the state associations, provider, and "grass roots" input to the state council was provided by representatives from each of the county and regional Emergency Health Service Councils.

The Pennsylvania Emergency Health Service Council is currently being directed by its four elected officers and the original 22 member steering committee. In January 1976, the original steering committee will be replaced by an elected board of trustees. This governing board will consist of six representatives of statewide associations, three representatives of county or regional Emergency Health Service Councils, two consumer representatives, and two members at large.

Within a year after its inception, the Pennsylvania Emergency Health Service Council had developed an organizational structure, developed and approved a comprehensive emergency medical services plan in conjunction with the Division of Emergency Health Services, and assisted in the development and production of public education programs on emergency services which were aired on public television networks throughout Pennsylvania on June 19, 1975.

Although still in its infancy, the Pennsylvania Emergency Health Service Council has demonstrated the enthusiastic and determined support of organizations throughout the state to work together in cooperation with agencies of state government in the development of emergency medical services systems. The council looks forward to assisting in the coordinated development of emergency medical systems on the local and regional level while continuing to broaden its role and activities in the areas of public and professional education, legislation, and communications.

Interested organizations and individuals may obtain additional information about participation in the activities of the council by writing to the Pennsylvania Emergency Health Service Council, c/o Division of Emergency Medical Services, Pennsylvania Department of Health, P.O. Box 90, Harrisburg, Pennsylvania 17120. □

Platelet Transfusion

The technique of harvesting platelets for the treatment of bleeding secondary to severe thrombocytopenia has been available for fifteen years. However, until recently platelet transfusions have not been available in many hospitals. From clinical experience, there is little need for platelet transfusions with circulating platelet counts above 40,000/MM³, and serious bleeding is seldom observed until platelet counts of 20,000/MM³ or less are present. Even at these low levels, capillary integrity is related to the age of circulating platelets. Therefore, the predominantly young platelets in destructive thrombocytopenia associated with such clinical states as idiopathic thrombocytopenic purpura (ITP), immune lysis of platelets after drug ingestion (e.g. Quinidine), or severe hypersplenism, may control purpuric bleeding at a platelet count of 5,000 to 10,000/MM³. Therefore, the physician should evaluate the pathogenesis of the thrombocytopenia rather than just the platelet count itself prior to ordering a platelet transfusion.

Platelet transfusions are indicated in most instances of severe thrombocytopenia secondary to the temporary decreased production of platelets such as one sees in patients on chemotherapy for hematologic malignancies such as leukemia, lymphoma, or other malignancies. Six to eight units of platelets should be given whenever the platelet count drops below 20,000/MM³ to *prevent* serious bleeding. Since antibodies to random platelets do develop, occasionally family members or even HL-A matched family donors can be used for regular platelet transfusions.

In aplastic anemia the patients are at risk for serious bleeding for months or years, and the prophylactic administration of platelets is not indicated, because of the development of platelet antibodies. Platelet transfusions should be reserved for actual bleeding episodes. Again, family members can be used as donors, unless bone marrow transplantation is a consideration.

Acute thrombocytopenias secondary to massive blood replacement, cardiac surgery, or splenomegaly are situations in which increased platelet destruction is the etiology of the thrombocytopenia. These situations are nevertheless reversible, and random donor platelet transfusions are effective in controlling acute bleeding episodes. Immune destruction of platelets (childhood or adult ITP), post-transfusion purpura, drug purpura, or consumptive thrombocytopenia seen in thrombotic thrombocytopenic purpura (TTP), or disseminated intravascular coagulation (DIC) are situations in which platelet transfusions are rarely, if ever, indicated. Thrombocytopathies without thrombocytopenia, such as the mucous membrane bleeding in uremic patients, hereditary thrombasthenia (Glanzmann's disease) and other rare hereditary platelet function disorders are disorders in which random donor platelet transfusions are also occasionally helpful.

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Reference: Gardner, Frank H. Use of Platelet Transfusions. British J. Hematology, 27:537-541, 1974.

Public education in emergency medical services

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ELLEN F. SAUNDERS
Lancaster

A broad program of public education is the only conceivable means by which a patient can obtain immediate emergency medical service at the moment it is needed. The necessity for this approach is portrayed by the following table published by the American Red Cross. It demonstrates the effect of delay in instituting cardiopulmonary resuscitation following cessation of circulation.

Delay	Chances of Recovery
1 minute	98 out of 100
2 minutes	92 out of 100
3 minutes	72 out of 100
4 minutes	50 out of 100
5 minutes	25 out of 100
6 minutes	11 out of 100
7 minutes	8 out of 100
8 minutes	5 out of 100
9 minutes	2 out of 100
10 minutes	1 out of 100
11 minutes	1 out of 1,000
12 minutes	1 out of 10,000

Obviously, some existing medical expertise must be transferred from the exclusive domain of the medical profession to the public if effective treatment is to be given within the few minutes available for the salvage of life.

The American Red Cross, American Heart Association, American College of Surgeons, and American Trauma Society are but a few public and professional organizations which have long devoted much effort to the development of citizen skills in the emergency care of the critically sick and injured. Emergency medical service has truly become a *cause celebre* largely because of public awareness of advances in EMS in many areas of the country.

Dr. DeMuth is chairman of the Society Commission on Emergency Medical Services. Ms. Saunders is director of safety programs for the Lancaster Chapter of the American National Red Cross.

The fledgling Pennsylvania Emergency Health Services Council, supported by virtually all agencies interested in EMS in the Commonwealth, has public education as a proper major objective.

In planning we must recognize the clear distinction between education and the mere dissemination of information to the public. Both are vital to success in establishing an emergency medical system. Public attention must be captured by those techniques which have proven successful in other areas of health care. Without this approach the Pap smear would still likely be an interesting laboratory curiosity of little general utility. This example is useful, too, in pointing up the great difference between those aspects of health care which are not urgent in nature and those which cannot be pursued at our convenience.

Once the character of emergency medical service gains public recognition, an organized educational program, preferably begun in childhood, is required. The Seattle experience in educating housewives to appropriately treat heart attack victims in the first minutes following the onset of the attack demonstrates what can be accomplished. The well trained and equipped cadre of life support personnel will not be financially supported if their need is not well recognized by the public. Two Pennsylvanians may owe their lives to the recent television production of the Pennsylvania Public Television Network entitled "A Stitch in Time."[1] After viewing the program and learning the warning signs of a heart attack, two unrelated persons presented themselves almost simultaneously to a hospital emergency room where acute myocardial infarction was diagnosed. Each patient credited the telecast with prompting him into seeking treatment.

Safar, et al,[2] have reminded us that a public information system has the following responsibilities:

1. Telling the public what to expect from an EMS system.
2. Telling the public how to recognize an emergency (laymen can be taught this). They can be taught to direct patients to appropriate hospitals and to recognize unconsciousness, apnea, pulselessness, respiratory insufficiency, circulatory insufficiency (massive hemorrhage, shock, heart attack), cerebral insufficiency, poisoning, crushing injury of the chest, multiple fractures, and major burns.
3. Stressing the desirability of emergency medical identification (wallet card, bracelet, necklace) for patients requiring special medication or who suffer from allergies or diseases (e.g., diabetes, epilepsy).

The scope of useful emergency medical education is very broad; however, quantitatively the greatest lifesaving potential lies with cardiac resuscitation when a "heart attack" is *suspected*. In order to have at least one trained person in each family, first aid courses and cardiopulmonary resuscitation instruction should become obligatory, not only for police and fire department personnel but also for those receiving driver's licenses.

The Comprehensive Emergency Medical Services Plan (Pennsylvania Department of Health, June 1975) projects the outline anticipated for

use in Pennsylvania. Its elements are:

I. Adult information and education
   A. Dissemination of information by media
      1. Public television
      2. Newspapers
      3. Supplements and speakers
   B. Instruction—responsibility to rest with American Red Cross
      1. Emergency Medical Technicians—instruction, teaching of skills, CPR, etc.
      2. Red Cross instructors—basic first aid and CPR
   C. Evaluation by testing—spot testing and opinion polls (American Red Cross)
   D. Manpower—mass media, volunteer speakers from EMS agencies
   E. Equipment—Red Cross, American Heart Association, and other organizations and by public contributions

II. Childhood education—public school teachers (health, physical education, etc.) will be instructed in basic first aid and cardiopulmonary resuscitation (American Heart Association and Red Cross)
   A. Fifth grade level—pulmonary resuscitation instruction.
   B. Eighth grade level—cardiopulmonary resuscitation (evaluation testing both groups at termination of course)
   C. Age 17 or at time of application for driver's license (Evaluation repeated at this time)

III. First aid education through school system

We heartily endorse these goals and propose their inclusion in the curricula of school systems.

These should be required competencies. This would mean that the student must possess valid certification in order to graduate from high school. This is by no means unique; the Commonwealth of Pennsylvania Department of Education has many requirements for high school graduation.

Education of the general public in life-saving skills belongs, ideally, in the educational institutions—the school system. Adults are often difficult to teach. They must be motivated to attend, overcoming fears of failure and embarassment. They have been out of a structured learning environment for a substantial amount of time and they often encounter problems in readjusting to classroom learning. If they work all day, they often arrive for a class mentally and physically tired, lacking the receptivity conducive to the retention of knowledge. Conversely, students currently in an academic environment are much easier to teach. Their "primary job" at the moment is attending school. Their minds are geared to structured learning situations. They seem to be more willing to try something new, since they have not had the many years in which to build up inhibitions and fears of "making a fool of myself." Since they are always the "teachee" while someone else is the "teacher," this is not an uncomfortable posture for them. Additionally, as much as we may deplore some of the incorrect emergency procedures viewed on television, these shows often provide motivational interest in emergency care in this age group.

Costs

The argument that cost is a prohibitive factor has been advanced. The costs are not as great as one might think and solutions can be found for those necessary items.

Manikins and films—Schools receive monies from the Pennsylvania Department of Health to be spent on health-related programs. The exact type of program is not specified as that is left to local discretion. These monies could be used for the purchase of manikins and films. If purchases are made through the Intermediate Unit, consolidation of buying and avoidance of duplication can be achieved. Schools or school districts wishing to have their own materials, can go to other sources for major items such as manikins. Manikins and films can often be borrowed until such time as purchase is practical. The following are some possible local resources:

Purchase

PTA or PTO project
Service club project
Industry donation
Town council
County government
Student fund raising project
Student council project
Groups from churches, temples, etc.
Boy Scout or Girl Scout project
Rescue squads fund raising project
Shared purchase with other schools
Private citizen donation

Loan

Hospitals or nursing schools
Industries

Laceration or Penetrating Injury in the Vicinity of a Joint

Did the laceration or penetrating injury in the vicinity of a joint actually enter the joint? The emergency department physician frequently has to make this judgment. It is particularly commonplace with injuries about the knee joint. Probing the wound is not the answer, since this can introduce infection into an otherwise clean area. The synovium may be injured by this maneuver, creating an open joint injury. An open joint injury must be recognized and must be treated in the operating room with debridement and copious irrigation. Two techniques are helpful. A syringe may be filled with sterile saline which may be injected into the joint at a point distant from the injury, using sterile technique. In the case of the knee joint, 40 or 50 cc of saline may have to be used. If the saline can be seen exiting from the joint injury, an open joint wound may be strongly suspected. To confirm this, 30 percent renographin may be injected until the joint is distended. Roentgenograms may then show the extent of the injury to the joint capsule and synovium which may be some distance from the skin wound itself.

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Mycotic Vulvovaginitis

A yeast infection of the vagina and/or vulva represents one of the most common and most symptomatic of gynecologic problems. Vulvar pruritis is the classic presentation with associated thick but occasionally minimal discharge. Women who are pregnant or who use oral contraceptives tend to have recurrent vulvovaginitis because of the increased glycogen in the vaginal epithelium. Glycogen serves as the substrate for the five or six yeast organisms known to infect the human. While there are a number of effective preparations available for treatment of mycotic vulvovaginitis there remains a group of women with frequent reinfections. These may occur as a result of the spread of the organism from the anus to the vagina and/or perineal area. In addition to local cleanliness, it may be desirable to periodically use topical therapy such as vaginal suppositories or external creams in these patients. Oral therapy is usually of only temporary help since the yeast organisms rapidly re-establish themselves in the gastrointestinal tract. A second common source of reinfection, often neglected in therapy, is the male sexual partner who may have yeast organisms, at least transiently, on his genital skin. Topical therapy for the male may prevent reinfection of his sexual partner after she has received effective therapy.

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American Trauma Society
Pennsylvania Division)

Since Basic First Aid (BFA) teaches only pulmonary resuscitation, a widely used and popular device called Resusci-Ralph can be utilized. He can be made by the junior or senior high school shop, vocational-technical students, or a community volunteer. Because adult manikins are often more difficult to ventilate than their human counterpart, youngsters may become discouraged when using them. Ralph, who is easier to use, solves this problem and teaches ventilation without frustration.

It should be noted that the American Red Cross has available 8mm hand viewers, an 8mm table model viewer and 8mm cartridges on CPR. The set of 6 cartridges covers all the skills and the film in each is on a continuous reel. The viewer's motion is controlled by the student and can be backed up to review any portion. There is no threading involved, as the cartridge is simply slipped into place and the student regulates his own visual aid. (Costs on these items: hand viewers, $6.00 each; set of 6 CPR cartridges, $17.50 per set; table model viewer, $19.95 each.)

Other materials and possible sources—Often local drug stores, surgical supply houses, clinics, or hospitals have bandaging material which is out of date, water stained, etc., which they will donate to schools for use in first aid classes.

Books—By agreement between the American National Red Cross and Doubleday and Company, Inc., libraries, institutions of learning, and boards of education may purchase all ARC textbooks from Doubleday, receiving an educational discount. Such purchasing informational requests should be directed to:

Doubleday and Company, Inc.
501 Franklin Avenue
Garden City, New York 11530
Attn: Mr. Jack J. O'Leary
Sales Manager
Institutional Sales Department

Training instructors

A Pennsylvania school teacher who wishes to become an American Red Cross Basic First Aid Instructor/Teacher, will take a 3 to 4 hour orientation course in which the following are covered: course content, course outline, skills which must be checked, and ARC standards and procedures.

A Pennsylvania school teacher who is to become an ARC Standard First Aid and Personal Safety Instructor will first take a Standard First Aid course. This will be followed by an instructor orientation course of approximately 3 to 4 hours. The same is true of cardiopulmonary resuscitation.

In many colleges in Pennsylvania, an education major who will graduate as a teacher is currently being trained in Standard First Aid and Personal Safety, the instructor course for Standard First Aid and Personal Safety, as well as Basic Life Support CPR. Consequently, many of the newer teachers coming from these colleges and universities into the Pennsylvania school system will already hold the proposed instructor ratings and can begin teaching immediately.

Course content

Basic First Aid (BFA)—Developed by Behavioral Engineering Associates, this course consists of four self instructional texts, divided into 20 lessons, and five teacher-led practice sessions. The teacher's manual is designed for use in the school system, with forty to fifty minutes allowed for one lesson. Topics covered are: shock, bleeding, poisoning, burns, fractures, rescue, head injuries, electric shock, pulmonary resuscitation, water safety problems, snake and animal bites, heat and cold exposure, internal bleeding, special safety problems, heart attack, etc., and prevention of accidents.

The course is outlined so that the students work through the texts at their own rate. A set of 36 BFA instructional charts (each chart is 22 by 28 inches) is available for $8.50 per set. A master completion log (for posting on the bulletin board), student's individual record card, and course completion certificate are all available through the Red Cross at no charge.

Standard First Aid and Personal Safety—Ideally, the teacher instructing this course would have the students for two 50 minute class periods per week for a semester. If necessary, however, teachers have taught this course having the students once a week for the 18 week semester. A sample outline, dividing the course into one hour segments, is in the back of the instructor's manual which the teacher receives upon completion of the orientation course. If the schedule permits the teacher to have the students twice a week, time will permit

Third Trimester Hemorrhage

When evaluating the patient with significant third trimester hemorrhage in an emergency setting, stabilization of the patient must take precedence over diagnostic procedures. Restoration of blood volume with intravenous fluids and plasma expanders will generally allow time for appropriate crossmatching of blood. There should be no hesitation in an acute hemorrhagic setting to use type-specific, uncrossmatched blood. Restoration of circulatory volume may be life saving both for the fetus and the mother. Vaginal examination should be performed only if delivery is made necessary by life threatening maternal hemorrhage or if the infant is felt to be viable if delivered. This should be done in an operating room prepared either for immediate cesarean delivery or vaginal delivery, depending upon the presence of a placenta previa. All patients with placenta previa should be delivered by cesarean section once fetal viability has been achieved. In the absence of a life threatening hemorrhage or a viable infant, placental localization studies using noninvasive techniques, such as ultrasound scan, radioisotopic scanning, and soft tissue x-ray placentography should be carried out and the patient watched expectantly.

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for the inclusion of "guest programs" which make the contents of the course relevant to the community.

Some possible guest programs are: (1) burns and fire prevention or electric shock and hazards, local fire department; (2) drugs and their abuse, local council on drugs or the police department; (3) frostbite and exposure to cold, National Ski Patrol or Campers and Hikers Association; (4) emergency rescue and transfer, Ambulance Association or Rescue Squad; (5) physiology and resuscitation of laryngectomee, local Laryngectomee Society or American Cancer Society; (6) drownings and water accidents, ARC Water safety instructor or YMCA aquatics instructor or Boy Scout swimming instructor; and (7) tips on boating safety and boating accidents, ARC small craft instructor, Coast Guard Auxiliary or Power Squadron.

It has been found that the addition of these guest programs has greatly enhanced the course. However, their inclusion must be on a time permitting basis and no first aid material can be eliminated to make time for these programs.

Topics covered in the Standard First Aid and Personal Safety courses include: shock, burns, wounds, bandaging, poisoning, sudden illness, splinting (fixation), specific injuries, swallowed objects and choking, control of bleeding, pulmonary resuscitation, airway, frostbite and cold exposure, heat stroke, exhaustion, cramps, injuries to upper and lower extremities, and emergency rescue and transfer.

It should be noted that the American Red Cross is constantly reviewing the content of all of its courses with the National Academy of Sciences whose approval is required prior to inclusion of a procedure in ARC courses.

Cardiopulmonary resuscitation (Basic Life Support)—Since the new standards for teaching this technique were published in the Journal of the American Medical Association (JAMA) supplement, it is important that all cardiopulmonary resuscitation be taught by these standards. Entitled Basic Life Support Course in CPR (as opposed to Advanced Life Support), the knowledge content and skill proficiencies required for certification in this course will necessitate approximately 6 to 8 hours of course time. There are several agencies teaching CPR and the local school district should insure that their students have the Basic Life Support Course in Cardiopulmonary Resuscitation as described in the Guidelines from the National Conference on Standards for Cardiopulmonary Resuscitation and Emergency Cardiac Care (ECC) as published in the supplement to JAMA (Volume 227, No. 7).

The BLS-CPR course should be taught as part of the Standard First Aid and Personal Safety course, since there is a natural progression from airway management through pulmonary resuscitation to cardiac resuscitation. Later reviews in CPR can be taught independently.

In addition to a basic understanding of the pulmonary and circulatory systems and the recognition of the presence or absence of these functions, the student learns the following proficiencies: establishment of an airway, techniques of pulmonary resuscitation, techniques of cardiac compressions combined with ventilations at proper ratio and timing, one-man rescuer CPR, two-man rescuer CPR, switching positions in two-man rescuer CPR, technique for cardiopulmonary resuscitation of infants and children, jaw thrust maneuver, modified jaw thrust maneuver for patients with possible neck fractures, technique for witnessed cardiac arrest (precordial thump), airway obstruction, gastric distention, resuscitation of a laryngectomee and special resuscitative situations. Included are the early warning signals of cardiovascular disease and additional information on the hazards in the performance of CPR.

It is imperative that the person instructing this course be a rated instructor who has been trained under the new standards for Basic Life Support. Professional personnel who are not rated by a teaching agency and decide to teach this course should be thoroughly conversant with the new standards. They should also be aware that while in-hospital teaching is done often without certification following the course, any ambulance, fire, police, national ski patrol personnel, etc., may be required by their own organizations or under the Good Samaritan Act to hold current and valid certification from a recognized teaching agency. □

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1. **Esposito, G.** Personal communication.
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Are you in good hands?

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Titusville

In any emergency involving the sick and injured, the individual at the scene most competent in emergency medical matters should assume the authority and responsibility for the patient's well being. When a person with a higher level of emergency medical care competency arrives, this authority and responsibility should shift to him. Does this philosophy exist in our Commonwealth? No, but for a few exceptions. We have a recognized problem; there is a solution. Let us look at a logical sequence of individuals we may encounter if sudden acute illness or injury strikes. Let us see what training they have in order to deal with our problem; and then, if deficiencies exist, suggest what steps should be taken to correct them.

Usually, the first person to attend the sick or injured individual is a family member or bystander. How much knowledge does this person have in the techniques of basic life support and the community's emergency medical services system? Generally, a citizen's response is to summon help first. If he is able to find his way to the communication network, who will be there to assist him?

Dr. Weigel is director of emergency medicine and critical care at North Hills Passavant Hospital, president of the Pennsylvania Chapter of the American College of Emergency Physicians, and treasurer and chairman of the professional training task force of the Pennsylvania Emergency Health Service Council. Dr. Resinger is treasurer and board member of the Pennsylvania Chapter of the American College of Emergency Physicians and on the steering committee and professional training task force of the Pennsylvania Emergency Health Service Council.

This is where the sequence of professional competency or incompetency begins to be evaluated in an attempt to solve the medical problem. The individual on the other end of the telephone should be a dispatcher manning an emergency operation communication center. Currently, personnel directing calls at these centers are usually not specifically trained in the emergency health service field. This lack of training can result in inadequate advice to callers or inappropriate assessment of medical problems and, therefore, failure to initiate a proper response. It is recommended that all the emergency operation communication center dispatchers be trained to the knowledge level of emergency medical technician-ambulance (EMT-Ambulance). It is also recommended that dispatchers receive specific training in emergency operation communication center procedures. Such personnel should then be certified every three years.

The second group of individuals involved in emergency care, and often the "first professional persons" on the scene, are the police and/or fire fighters (first responders). Currently, the first responders in Pennsylvania are not required to take specific first aid or basic emergency medical technician (EMT) care courses. Therefore, it is recommended that all police officers take the Department of Transportation "Crash Injury Management Course" or its approved equivalent. This course is a distillation of the EMT-Ambulance course and is appropriate training for first responders. Proper first aid rendered by such personnel may well reduce morbidity and mortality. Persons who successfully complete the course will be certified by their county or regional health service council. Certificates will be renewed every three years upon successful completion of a re-examination. It is also recommended that all fire fighters be trained in first aid and emergency care beyond the level established by the National Fire Protection Association (NFPA) for Fire Fighters II in NFPA Standard 1001.

The ambulance squad personnel, summoned by either the dispatcher or the first responder, will be the next group with a higher level of emergency medical care competency to render aid. At present, there are no statutory training standards for ambulance personnel in Pennsylvania. The only statutory inducement to obtain any training in Pennsylvania is contained in the Good Samaritan Act which is limited in scope.

EMT-Ambulance training centers are now organized and functioning primarily in hospitals, community colleges and area vocational-technical schools. Course directors may be physicians, nurses, or allied health professionals. It is strongly recommended that every course without a physician director have an interested, knowledgeable physician advisor. Those who successfully complete the basic training program for EMT-Ambulance and pass a written and practical examination are awarded a certificate and wallet card by the Division of Emergency Health Services of the Commonwealth. A 20-hour recertification course is currently being developed and will be administered this fall.

EMTs-Ambulance are not taught intravenous infusion therapy, administration of parenteral drugs, definitive coronary care, or ventilation via endotracheal intubation. A higher

level of emergency medical care training, EMT-Advanced, has been proposed in which these skills would be taught. Pilot projects are underway in the United States to develop an educationally and medically approved curriculum. The University of Pittsburgh School of Medicine has recently been awarded a grant by the federal government to develop national standards and curriculum for such a course.[1]

The number of EMT-Advanced personnel needed in Pennsylvania is unknown but should be considerably less than the number of EMTs-Ambulance needed. When we gain a better understanding of the potential of highly skilled ambulance personnel, the number of required EMTs-Advanced will become more readily apparent. Selected hospitals, in cooperation with area vocational-technical schools, community colleges, or institutions of higher learning, will be responsible for training students to the EMT-Advanced level. This entire program must come under medical direction. The Pennsylvania Department of Health will establish minimum performance standards for EMT-Advanced personnel based on anticipated national standards. It is planned that such personnel will be given a certifying examination by the Commonwealth. Recertification will be required every three years.

Qualified instructors are essential to successful EMT-Ambulance training programs. Pilot projects are being conducted to identify potential instructors for placement in "method of instruction" courses.

Legislation, defining "emergency medical technician" and authorizing such persons to perform certain basic definitive medical services, has been introduced into the Pennsylvania General Assembly. If enacted, this legislation will also provide protection from civil liability for the activities of both the EMT-Ambulance and EMT-Advanced personnel.

The acutely sick or injured, in most instances, will ultimately find themselves in a hospital emergency department and in the hands of in hospital professionals. Most of the public assumes that these professionals (nurses and physicians) are highly trained for emergency work. Not necessarily true! Emergency department nurses are usually not specifically prepared for these responsibilities. In a recent study of nursing schools in Southeastern Pennsylvania, it was revealed that 80 percent of the schools did not teach emergency care; the remaining 20 percent taught little more than basic first aid.[2]

Emergency departments should be staffed by nurses who have satisfactorily completed additional training in advanced life support. Advanced life support for nurses includes: external hemorrhage control; management of shock through I.V. therapy; basic and definitive cardiopulmonary resuscitation including diagnostic cardioscopy and parenteral medication; management of respiratory distress, including oxygen inhalation, endotracheal intubation, and airway suction; decompression of the pleural space; and management of fractures.[3]

It is recommended that *all* nurses receive formal education in emergency care as part of the nursing core curriculum and that nursing schools in Pennsylvania be required to introduce advanced emergency nursing studies into their curricula and provide postgraduate instruction, using guidelines provided by the Emergency Department Nurses Association (EDNA).

Continuing education through in-service courses for emergency nurses will be encouraged at hospitals and other educational institutions. The present Emergency Department Emergency/Ambulatory Nurse Practitioner Pilot Program,[4] being conducted in Pittsburgh at Allegheny General Hospital, will be scrutinized; if successful, efforts will be made to develop similar courses in other hospitals in the Commonwealth. Certification and recertification standards will be based on the results of the pilot project.

It is anticipated that nurses trained to the level of emergency department nurse practitioner, while helping to provide improved care in the urban emergency departments, will be extremely valuable to the emergency departments of small hospitals where physician coverage is not feasible at all times.

We have described a cadre of paraprofessionals and professionals whom the public feels have some expertise in emergency medical care and who really, except for some areas in the Commonwealth, have very little or no formal emergency care training. Even among physicians, few have been specifically trained as emergency physicians. There are 32 emergency medicine residency programs in the United States; two of these are in Pennsylvania. Physicians should be encouraged to take self-assessment examinations to delineate their strengths and weaknesses in emergency medicine. Post graduate courses in the form of seminars and workshops are available to help physicians develop specific knowledge and skills in emergency medicine. Medical and osteopathic schools in the Commonwealth will be asked to develop emergency medicine curricula for their medical students. Recommendations for such curricula are available from the American College of Emergency Physicians (ACEP) and the University Association for Emergency Medical Services. Emergency medicine residency program development will be encouraged. An emergency medicine board examination will be developed and available by 1977.

It is sad that we have neglected for so long individual persons who become suddenly ill or injured. Let us now move forward with our new advances and technology and begin to upgrade all the components of the emergency medical services system, particularly those individuals in whom we entrust our very being. A cooperative effort of state government by providing legislation and financial support; ACEP and EDNA by providing expertise and guidance; ambulance providers, local government, and all other emergency medical groups, by providing services; will ensure that injured individuals enter into the total system quickly and effectively. □

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3. Commonwealth of Pennsylvania Comprehensive Emergency Medical Services Plan, Section III, Page 5, June 1975.

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Emergency medical communications in Philadelphia

DAVID G. FARIS, M.D.

EDGAR P. GRIM

Philadelphia

Most medical emergencies requiring ambulance transportation to a hospital involve communications among several individuals. In the past in Philadelphia, these communications have often been only between the patient, or someone helping the patient, and either the police department, the fire department, which operates our rescue squads, the volunteer ambulance corps, or private ambulance companies. There are many difficulties with this simple form of communication. The caller may not know or be able to find the telephone numbers of the police and fire departments; he may not know of the existence of volunteer ambulance corps, their telephone numbers, or the territories in which they operate. The same is true of the private ambulance companies; in addition, the patient may be unable or unwilling to pay the substantial charges for such service. In this situation, considerable delay and confusion can result to the patient's detriment.

To meet this need, modern all-inclusive medical communications facilities are required to give patients or persons assisting them a single, simple, easily remembered, and quickly dialed telephone number that will reach an emergency operations center. Dispatchers answering calls know the availability of the nearest ambulance-type vehicle, can dispatch it promptly, elicit facts about the patient's condition from the caller, know the availability of emergency services in nearby hospitals, alert the hospital to the patient's impending arrival, and communicate with the hospital and ambulance personnel. The patient can then receive appropriate treatment on site and en route to the hospital.

In Philadelphia these essential requirements are being met by the following:

1. Adoption of the nationwide emergency telephone number 911 and an educational program to train the public to use this number only "To Stop a Crime or Save A Life." Other telephone numbers are publicized to reach police and fire services in nonemergency situations.

2. A 911 call is answered at ten police communications consoles corresponding to the ten sections into which Philadelphia is divided for police purposes. Calls originating in each of the ten areas are received via special dedicated telephone trunks by the console having responsibility for police services to that particular district. This allows the dispatchers to become very familiar with addresses in their particular district.

3. If the incoming call is "to save a life" requiring emergency on-site medical services and transportation to a hospital, the dispatcher, by depressing a button on his telephone console, contacts the fire department dispatcher instantly and a three way conference call is immediately created among the incoming caller, the fire dispatcher, and the police dispatcher.

4. The fire dispatcher is trained to elicit essential information from the caller, including the location of the patient and sufficient information about his condition and symptoms. This enables the fire dispatcher to determine whether to dispatch: (a) a medical intensive care unit, manned by firemen paramedics and equipped with cardiac defibrillator, selected emergency drugs and intravenous fluids; (b) the regular rescue squad manned by firemen with 81 hours of emergency medical technician training and supplied with oxygen, airways, and ordinary first aid equipment; or (c) a police wagon for nonemergency cases manned by policemen with first aid training.

5. The fire rescue vehicles are equipped with both mobile radios in the vehicles and portable radios, which the Emergency Medical Technicians (EMTs) who man the vehicles can take with them when they leave the vehicle to attend the patient. Upon initial examination of the patient, the EMT radios his observation back to the dispatcher at Fire Dispatch Headquarters. In serious cases, in particular the pulseless, nonbreathing patient in ventricular fibrillation, the firemen paramedics, but not the firemen trained to the EMT-Ambulance level, may treat according to the physician directed protocol.

6. Depending on the nature of the report he receives from the EMT or paramedic, the dispatcher contacts the nearest appropriate hospital via a city owned telephone network which is connected to the emergency departments of every general hospital in the city. By means of a telephone-radio patch connection a physician at the hospital can talk directly to the EMT at the patient's side, receive information on the patient's condition, and advise the EMT as to what procedures he should take there and while transporting the patient to the hospital. The physician can also prepare for the patient's arrival by ordering blood, plasma, special medications, or equipment to be available on the pa-

Dr. Faris is director of Emergency Medical Services in the Department of Public Health for the City of Philadelphia. Mr. Grim is chief of communications and the special services division of Philadelphia's Department of Public Property.

tient's arrival at the hospital. He can also arrange for availability of an operating room, the summoning of a surgeon, cardiologist, or other specially needed personnel so that the patient can have the best possible treatment for his problem with the least possible delay.

The 911 telephone number and the city owned telephone network with the hospitals have been established with city funds. Funds supporting the specialized training and equipping of the fire rescue personnel have come from the city, a private bequest and the Robert Wood Johnson Foundation. Two mobile intensive care units are presently in operation and four more will be added in the next six months.

Ultra high frequency transmission of voice communication between the Emergency Medical Technician at the scene and hospital personnel is being implemented. A major problem in this area is that the Federal Communications Commission has allocated only eight radio channels for emergency medical communications purposes throughout the entire nation. This requires discipline in the sharing of these channels within regions of the country to avoid the interference problems with several rescue units trying to talk on the same radio channel simultaneously. To solve this problem for the Philadelphia area, meetings are being held with the communications directors of the five Southeastern Pennsylvania counties and with the three neighboring New Jersey counties as well. Progress is being made at these meetings but definitive conclusions have not yet been reached.

The single emergency telephone number 911 became available in American Telephone and Telegraph Company service areas in January 1968. The Federal Office of Telecommunications' policy in March 1973 endorsed the concept and urged nationwide implementation of 911. By the end of 1973 seven communities in Pennsylvania had adopted 911: Bradford, Clearfield, DuBois, Greensburg, Milton, Norwood, and Tarentum. After the City of Philadelphia began using 911 in March 1974, the number of city telephones on 911 equaled about one quarter of the total in Pennsylvania.

The implementation of a 911 emergency reporting system requires the planning of public safety agencies, local government, and telephone companies. The handling of the calls received by 911 depends on local conditions. The communications center may handle ambulance dispatching directly, may transfer the call to the appropriate agency, or relay the necessary information to that agency.

The most sophisticated recent development in emergency medical communications has been the introduction of biomedical telemetry, which allows for a hospital based physician's interpretation of data to be followed by advice on patient care at the scene. This transmission is also carried by special emergency medical frequencies in the UHF range and accompanied by voice transmission concerning patient care. The problems of transmission interference alluded to earlier, in connection with UHF voice transmission, also obtain for biomedical telemetry. □

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1 It is recognized that T_4 and T_3 content in desiccated thyroid and thyroglobulin varies from animal to animal, by animal species, geography, and animal diet.

2 Of therapeutic concern: In addition to varying amounts of T_4, desiccated thyroid may contain varying amounts of T_3, a potent compound with rapid onset and fleeting action that can produce metabolic surges.

3 Even when kept under proper storage conditions, desiccated thyroid deteriorates more rapidly than the synthetic hormone.

4 The "usual maintenance dose" for the widely prescribed desiccated thyroid is "from 1 grain to 3 grains per day, but it may vary, in individual patients from 1/2 grain to 10 grains."[1] The "usual maintenance dose" of the most widely prescribed thyroglobulin (which is also a desiccated thyroid product) is "0.5 to 3.0 grains daily."[2]

1. Armour Thyroid (Tablets). 1975 Physicians' Desk Reference. p. 561.
2. Proloid® (thyroglobulin). 1975 Physicians' Desk Reference. p. 1575.

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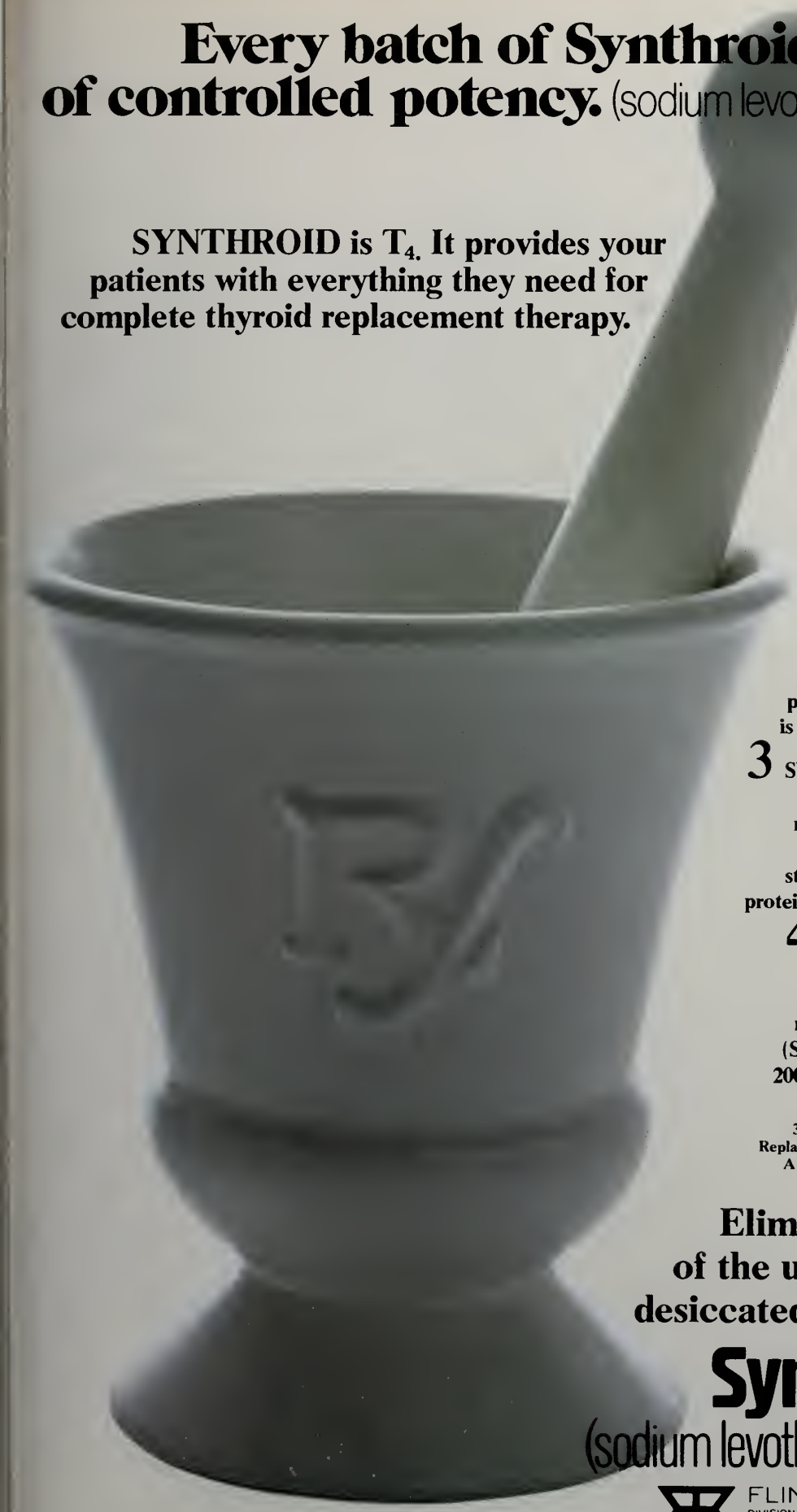

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2 SYNTHROID (sodium levothyroxine) is T_4 which is converted by the patient to T_3 at the cellular level, thereby providing a physiologic source and amount of T_3 to meet metabolic needs for complete thyroid replacement therapy. Because the onset of effect is slower and more steady, the possibility of sudden metabolic surges is reduced with SYNTHROID therapy.

3 SYNTHROID (sodium levothyroxine) products have a longer and more reliable shelf life than Thyroid U.S.P. when kept under the same proper storage conditions. There is no animal protein present in SYNTHROID products.

4 A recent study of 44 patients with hypothyroidism indicates that 89 percent of the patients were maintained with doses of L-thyroxine (SYNTHROID) between 100 mcg. and 200 mcg. (0.1 mg. and 0.2 mg.) per day.[3]

3. Stock, J.M., Surks, M.I., and Oppenheimer, J.H.: Replacement dosage of L-thyroxine in hypothyroidism. A re-evaluation. New Engl. J. Med. *290*:529-33, 1974.

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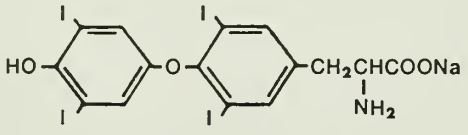
SYNTHROID (sodium levothyroxine) **Tablets** and SYNTHROID **Injection** contain synthetic crystalline sodium levothyroxine (L-thyroxine). L-thyroxine is the principal hormone secreted by the normal thyroid gland.



Sodium Levothyroxine

Actions

SYNTHROID (sodium levothyroxine) **Tablets**, taken orally, provide hormone that is readily absorbed from the gastrointestinal tract. SYNTHROID **Injection** is effective by any parenteral route. Following absorption, the synthetic L-thyroxine provided by SYNTHROID products cannot be distinguished from L-thyroxine that is endogenously secreted. Each is bound to the same serum proteins and each exhibits a six to seven day circulating half-life in the euthyroid individual.

Both SYNTHROID products will provide L-thyroxine as a substrate for physiologic deiodination to L-triiodothyronine. Therefore, patients taking SYNTHROID products will demonstrate normal blood levels of L-triiodothyronine even when the thyroid gland has been surgically removed or destroyed by radioiodine. Administration of levothyroxine alone will result in complete physiologic thyroid replacement.

Indications

SYNTHROID (sodium levothyroxine) products serve as specific replacement therapy for reduced or absent thyroid function of any etiology. SYNTHROID **Injection** can be used intravenously whenever a rapid onset of effect is critical, and either intravenously or intramuscularly in hypothyroid patients whenever the oral route is precluded for long periods of time.

Contraindications

There are no absolute contraindications to SYNTHROID (sodium levothyroxine) therapy. Relative contraindications include acute myocardial infarction, uncorrected adrenal insufficiency and thyrotoxicosis. (See WARNINGS)

Warnings

Patients with cardiovascular diseases warrant particularly close attention during the restoration of normal thyroid function by any thyroid drug. In such cases, low initial dosage increased slowly by small increments is indicated. Occasionally, the cardiovascular capacity of the patient is so compromised that the metabolic demands of the normal thyroid state cannot be met. Clinical judgment will then dictate either a less-than-complete restoration of thyroid status or reduction in thyroid dosage.

Endocrine disorders such as diabetes mellitus, adrenal insufficiency (Addison's disease), hypopituitarism and diabetes insipidus are characterized by signs and symptoms which may be diminished in severity or obscured by hypothyroidism. SYNTHROID (sodium levothyroxine) therapy for such patients may aggravate the intensity of previously obscured symptoms and require appropriate adjustment of therapeutic measures directed at these concomitant disorders.

Thyroid replacement may potentiate the effects of anticoagulants. Patients on anticoagulant therapy should have frequent prothrombin determinations when instituting thyroid replacement to gauge the need to reduce anticoagulant dosage.

Precautions

Overdosage with any thyroid drug may produce the signs and symptoms of thyrotoxicosis, but resistance to such factitious thyrotoxicosis is the general rule. With SYNTHROID (sodium levothyroxine) **Tablets**, the relatively slow onset of action minimizes the risk of overdose but close observation in the weeks following institution of a dosage regimen is advised. Treatment of thyroid hyperactivity induced by oral medication is confined to interruption of therapy for a week, followed by reinstitution of daily therapy at an appropriately reduced dosage.

Adverse reactions

Adverse reactions are due to overdose and are those of induced hyperthyroidism.

Dosage and administration

For most adults, a final dosage of 100 mcg (0.1 mg) to 200 mcg (0.2 mg) of SYNTHROID (sodium levothyroxine) **Tablets** daily will restore normal thyroid function and only occasionally will patients require larger doses. Failure to respond adequately to a daily oral intake of 400 mcg (0.4 mg) or more is rare and should prompt reconsideration of the diagnosis of hypothyroidism, special investigation of the patient in terms of malabsorption of L-thyroxine from the gastrointestinal tract or poor adherence to therapy.

The concomitant appearance of other diseases, especially cardiovascular diseases, usually dictates a replacement regimen with initial doses smaller than 100 mcg/day (0.1 mg).

In otherwise healthy adults with relatively recent onset of hypothyroidism, full replacement dose of 150 mcg (0.15 mg) or 200 mcg (0.2 mg) has been instituted immediately without untoward effect and with good therapeutic response. General experience, however, favors a more cautious approach in view of the possible presence of subclinical disorders of the cardiovascular system or endocrinopathies.

The age and general physical condition of the patient as well as the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage. In the elderly patient with long standing disease, evidence of myxedematous infiltration and symptomatic, functional or electrocardiographic evidence of cardiovascular dysfunction, the starting dose may be as little as 25 mcg (0.025 mg) per day. Further incremental increases of 25 mcg (0.025 mg) per day may be instituted at three to four week intervals depending on patient response. Conversely, otherwise healthy adults may be started at higher daily dosage and raised to the full replacement dosage in two to three weeks. Clearly it is the physician's judgment of the severity of the disease and close observation of patient response which determines the rate of dosage titration.

Laboratory tests to monitor thyroid replacement therapy are of limited value. Although measurement of normal blood levels of thyroxine in patients on replacement regimens frequently coincides with the clinical impression of normal thyroid status, higher than normal levels on oral replacement of levothyroxine occasionally occurs and should not be considered evidence of overdosage per se.

In all cases, clinical impression of the well-being of the patient takes precedence over laboratory determination in determining the appropriate individual dosage.

In infants and children, there is a great urgency to achieve full thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult, as much as 300 mcg (0.3 mg) to 400 mcg (0.4 mg) per day.

In myxedema coma or stupor, without concomitant severe heart disease, 200 to 500 mcg of SYNTHROID **Injection** may be administered intravenously as a solution containing 100 mcg/ml. Although the patient may show evidence of increased responsivity within six to eight hours, full therapeutic effect may not be evident until the following day. An additional 100 to 300 mcg or more may be given on the second day if evidence of significant and progressive improvement has not occurred. Like the oral dosage form, SYNTHROID **Injection** produces a predictable increase in the circulating level of hormone with a long half-time. This usually precludes the need for multiple injections but continued daily administration of lesser amounts intravenously should be maintained until the patient is fully capable of accepting a daily oral dose.

In the presence of concomitant heart disease, the sudden administration of such large doses of L-thyroxine intravenously is clearly not without its cardiovascular risks. Under such circumstances, intravenous therapy should not be undertaken without weighing the alternative risks of the myxedema coma and the cardiovascular disease. Clinical judgment in this situation may dictate smaller intravenous doses of levothyroxine.

SYNTHROID **Injection** by intravenous or intramuscular routes can be substituted for the oral dosage form when ingestion of SYNTHROID **Tablets** is precluded for long periods of time.

How supplied

SYNTHROID (sodium levothyroxine) **Tablets** are supplied as scored, color-coded compressed tablets in 6 concentrations: 25 mcg (0.025 mg)—orange . . . 50 mcg (0.05 mg)—white . . . 100 mcg (0.1 mg)—yellow . . . 150 mcg (0.15 mg)—violet . . . 200 mcg (0.2 mg)—pink . . . 300 mcg (0.3 mg)—green. Depending on strength, these tablets are available in bottles of 100, 500, 1000 and 5000.

SYNTHROID (sodium levothyroxine) for **Injection** is supplied in 10 ml vials containing 500 mcg of lyophilized active ingredient and 10 mg of Mannitol, U.S.P. A separate 5 ml vial containing Sodium Chloride Injection, U.S.P. is provided as a diluent.

Directions for reconstitution

Reconstitute the lyophilized sodium levothyroxine by aseptically adding 5 ml of the Sodium Chloride Injection, U.S.P. to the vial. Shake vial to insure complete mixing. **Use immediately** after reconstitution. Discard any unused portion.

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Transportation and emergency medical care

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Efforts to transport injured soldiers to sequentially advanced levels of emergency medical care were first organized in the United States during the Civil War. A system was subsequently developed and refined that today permits military personnel to receive stabilization at the site of injury or illness and prompt transportation from the battlefield through a series of temporary and permanent medical care facilities.

The most frequent mode of military transportation is the motor vehicle, although helicopter evacuation during the Vietnam conflict permitted faster evacuation for seriously injured personnel. Evacuation by air permitted bypassing some facilities to permit successful intervention at facilities with appropriate capability.

Although civilian demands and capabilities are different and far more diverse than the military, the fact that an American soldier in southeast Asia had a 40 percent better chance of survival than his civilian counterpart with similar injuries in the United States[1] mandates a consideration of the military emergency medical care and transportation system.

Briefly, the military system stresses immediate application of basic and advanced life support techniques by specially trained personnel, the continuation of that care until professional intervention is possible, and prompt transport through a system designed to stabilize and treat patients at progressively advanced levels.

Civilian efforts to provide emergency medical care must be viewed from a different perspective, although the ideal system will encompass some aspects of the military system. The advantages of the military—a unified organization that can be organized rather easily to accomplish a goal, and a need pattern capable of both definition and prediction—do not apply to civilian life. No one in a diverse, democratic society can effectively promulgate a general order. It is far more difficult to allocate personnel and equipment to meet the needs of a few scattered patients than the needs of dozens in the same place at a predictable time.

The ambulance service

Ambulances today serve a dual role—delivery of emergency medical personnel and equipment to the patient, and transport of the patient to a medical facility. With the appearance of the first motor driven ambulance in 1906,[2] physicians responded with the vehicle and initiated basic care upon arrival at the scene.

This practice soon gave way to economic factors and the limited availability of physicians. Responsibility for the link between onset of sudden illness or trauma and emergency medical care facilities was delegated to whomever would accept it. In Pennsylvania in 1970, 671 of 1018 ambulance services were operated by volunteers, 200 by funeral directors and 73 by commercial firms.[3] Hospitals, which operated 9 services in 1970, also relied for the most part on nonprofessional personnel.[4]

As a general rule in 1970, the training of personnel and the equipment and design of the ambulances varied widely. Station wagons and limousine-type vehicles predominated. Training of personnel ranged from none to a little.[5]

With the infusion of Federal highway safety funds, and an increased concern for emergency medical care by a number of organizations and individuals, the last five years have seen almost incredible change.

The Pennsylvania Department of Health will have certified almost 10,000 Emergency Medical Technicians-Ambulance by the end of 1975. This certification involves an 81-hour course and is physician taught under Federal and Commonwealth guidelines. The advent of Emergency Medical Technicians-Ambulance in the field of pre-hospital emergency care, and the availability of Federal funds for equipment and ambulance vehicles, has initiated sweeping changes in many areas of Pennsylvania.

The time honored concept that ambulances are primarily transport vehicles—and therefore race to the scene of an emergency, scoop up a victim, and careen to a hospital where emergency medical care begins—has begun to give way to the concept that the ambulance delivers emergency medical equipment and personnel to the scene, where basic life support and stabilization begin. Such support and stabilization continue through transport until a facility providing definitive care is reached.

Although Pennsylvania's Medical Practice Act neither permits nor forbids advanced life support activities by specially trained paramedical personnel,[6] several hospitals have initiated advanced life support through mobile intensive care units. A measure pending before the Pennsylvania Legislature would permit the Secretary of Health to set standards and initiate training and certification procedures for advanced life support personnel. Advanced life support techniques would include drug and intravenous therapy, endotracheal intubation, defibrillation, and other necessary techniques performed by trained, Commonwealth-certified personnel on a physician's order.[7]

Ambulance design and equipment

A change in concept (care rather than rapid transport) has led to altered methods by which individual ambulance services choose their vehicles. Station wagons and expensive limousine-type vehicles have given

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Scalp Lacerations

Generally, too much hair is shaved around the area of the wound. Only a minimal amount need be trimmed, if at all, in the approximation of these wounds. If the edges are to be excised the knife blade should parallel the direction of the hair so that hair follicles are not undercut, divided and a streak of bald scar develop. Too many physicians use occlusive dressings or aeroplast type sprays on the scalp. These are totally unnecessary additions. The wounds heal better if they are left open and if shampooing or washing the hair is started the day after injury and continued every third or fourth day thereafter, until the sutures are removed at seven to fourteen days.

Facial Lacerations

The preferred suture is monofilament nylon rather than silk. It is good to use as fine a suture as possible on the face, preferably 6-0 and occasionally 5-0. These are placed as simple interrupted or a continuous non-locking running suture. The patients are given an instruction sheet and started on washing the wounds the day of surgery. Cleanliness over the wound area with soap and water is stressed in terms of good wound healing. The sutures are removed somewhere between three and five days depending on the location of the injury and steri-strips are then applied. These are left on for the next two to three days and the patient generally removes these at home himself.

The normal maturation of the wound is stressed and the problems that might develop are explained to the patient at the time of his injury and reinforced again at the time of the first revisit. No dressings are necessary on the face and are probably contraindicated.

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way to larger vans and modular vehicles.

Three basic body types are now recommended by the Federal government: the enlarged van type; the modular type (a truck chassis usually mounted on a heavy duty suspension, upon which a large box type body is constructed); and a combination style which features a van-type cab and the box.[8] The last type offers access between cab and patient compartment, which the standard modular does not, and provides more room than the standard van with raised roof.

In addition to the capability for storage, another advantage of the larger ambulance vehicles is that they provide more room for basic life support procedures, such as cardiopulmonary resuscitation, to be carried out.

The equipment on these ambulance vehicles has also changed. Installed suction and humidified oxygen delivered through a liter gauge is now common. Many ambulances carry light rescue tools for traffic accidents, a variety of orthopedic litters, stair chairs, etc., and an assortment of other equipment and supplies ranging from emergency obstetric kits to special portable suction and oxygen units.

Future emergency transportation

Each citizen in Pennsylvania who needs emergency medical care must be guaranteed the prompt arrival of trained personnel who are properly equipped to render at least basic life support.

The initial delivery of emergency care to the scene should be a task force approach. Specially equipped police, fire, and rescue units should respond automatically to cut the time gap between dispatch and arrival and provide adequate personnel and equipment.

Advanced life support capability must be made available to as many of those in need of it as possible.

Rural transportation and emergency medical care need to be improved and expanded in all facets, given the wide gap between the rural and urban death rates due to trauma.[9]

Alternate modes of emergency care delivery and transport need to be explored; in particular, air transport both by helicopter and fixed wing.

These are only a few of the many aspects of emergency medical care and transportation that must be explored and developed to full potential. The improvement over the past five years in the delivery of emergency medical care has been impressive, but in the perspective of need, there is much more to do.

The technology for improved transportation modes exists. No new scientific breakthroughs are needed. What is needed is the fundamental coordination of the diverse and fragmented elements that form the framework of emergency medical care and transportation. Without the fulfillment of that process, the progress made yesterday becomes tomorrow's status quo—and that's simply not good enough. □

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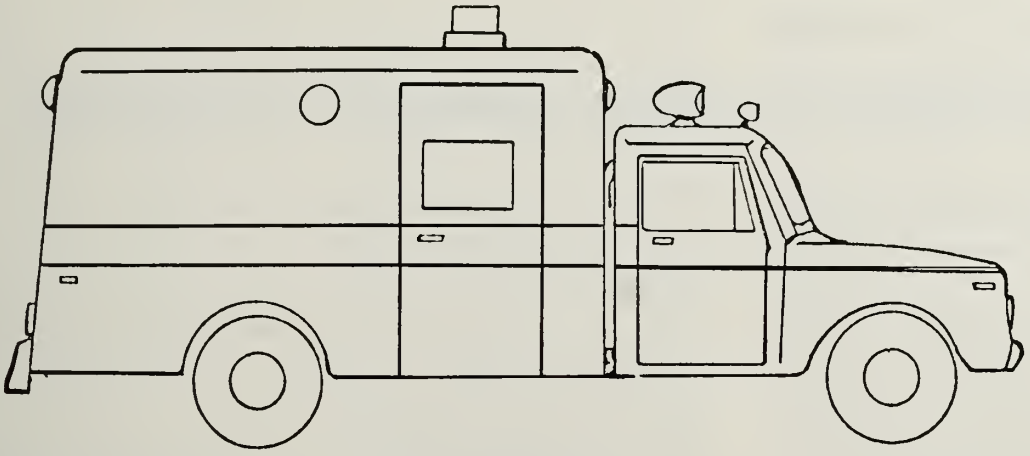
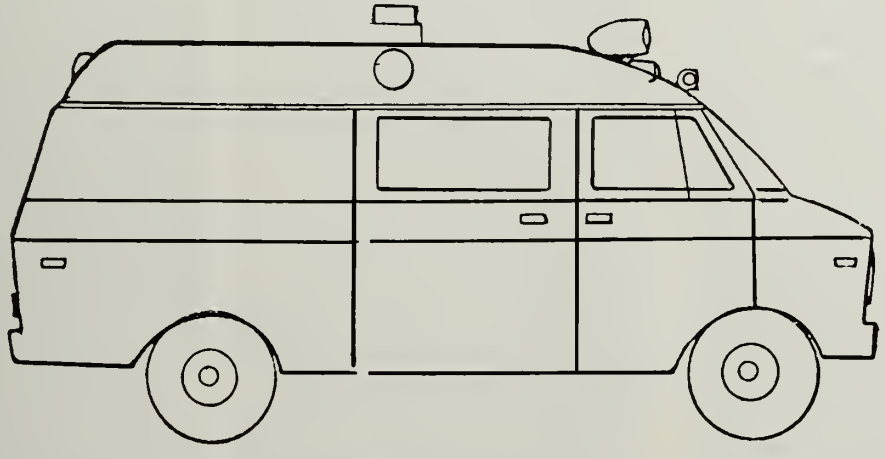
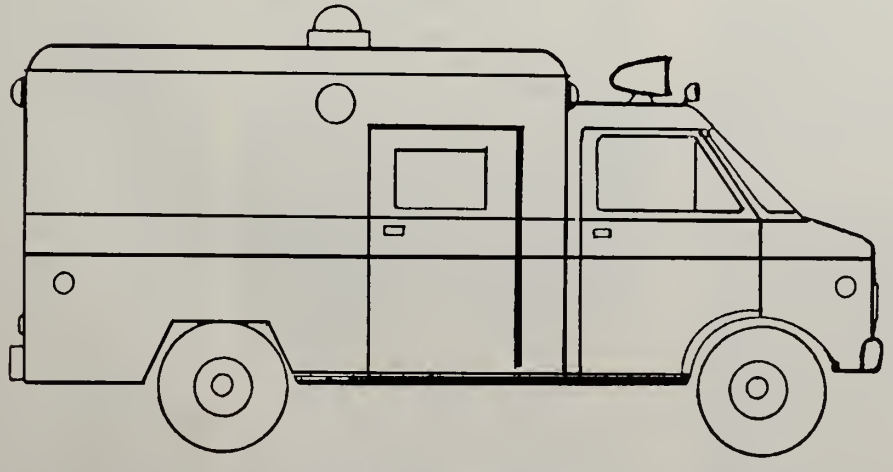


Type I Ambulance
(Conventional cab-chassis with modular ambulance body)



Type II Ambulance
(Standard Van, forward control, integral cab-body ambulance)



Type III Ambulance
(Specialty Van, forward control, integral cab-body ambulance)

Development of a concept

Categorization of hospital emergency capabilities

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Many individuals in the fields of health, government, and public safety intent on improving emergency medical services have advocated a system of categorization of hospital emergency capabilities. The concept of categorization originated from the realization that emergency patients occur with varying magnitudes of injury and illness and that all hospitals have varying capabilities with which they can provide adequate initial and/or definitive care. Basically, categorization is an attempt to match the patient's needs for emergency medical care with the most appropriate hospital emergency facilities in a specific region through functional knowledge and classification of the emergency resources in the region.

Most patients can be adequately cared for in most hospital emergency departments. It is estimated that only 5 percent of the patients entering hospital emergency departments would benefit from categorization.[1] In every community there should be three areas of concern regarding hospital emergency facilities. First, what is the general capability of each hospital emergency department? Second, what specialized services exist in a region for the care of the critically ill and injured? Finally, how do hospitals relate to each other in providing a full range of emergency services around the clock?

Categorization of hospital emergency capabilities is considered an early and important first step in the implementation of an effective emergency medical services system. An assessment of the emergency medical care capabilities available in hospitals provides the necessary groundwork for the development of regional triage and care patterns and establishes the need for other essential components (e.g., communications, transportation, and training) Three primary reasons are given in support of the need to categorize hospital emergency capabilities:

1. The nearest hospital is not always the most appropriate facility to receive a patient with a serious illness or injury.

2. The costs are high if all hospitals are required to have the services available to handle all types of emergencies.

3. There are inadequate numbers of trained personnel available to provide full coverage in every hospital.

Although many have advocated programs in categorization, a recent report from the Department of Health, Education, and Welfare, Division of Emergency Medical Services indicates that very few regions have planned for categorization and a lesser number have implemented categorization into a total emergency medical services system.[1]

The initial stimulus for categorization came in 1966 when the National Academy of Sciences-National Research Council published a "white paper" relating to emergency medical services.[2] This report entitled, "Accidental Death and Disability: the Neglected Disease of Modern Society," pointed out the fact that death and disability from accidents was appalling. Among the recommendations made in the report was the need for accreditation and categorization of hospital emergency departments.

In 1969, the Committee on Trauma of the American College of Surgeons and the Committee on Injuries of the American Academy of Orthopaedic Surgeons sponsored a conference on emergency medical services. The participants representing various disciplines recommended that categorization of hospital emergency departments be included in the Standards of the Joint Commission on Accreditation of Hospitals. This recommendation was accepted and initiated in 1971 when the Joint Commission included a new factor in their standards—a community plan and each hospital's participation in such a plan. The first standard regarding emergency services states, "A well-defined plan for emergency care, based on community need and on the capability of the hospital shall exist within every hospital."

In December 1971, the American Medical Association's Commission on Emergency Medical Services published its recommendation on guidelines for categorization of hospital emergency capabilities.[3] This document included more than the emergency department; it involved the entire capability of the hospital to provide emergency medical care. The AMA guidelines recommended a categorization system with four graduations of hospital emergency services: comprehensive, major, general, and basic.

The initial federal requirement for categorization was specified in im-

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plementing the program directives of the Highway Safety Act of 1966. More recently, the Emergency Medical Services System Act of 1973 clearly requires categorization for those areas funded under this act. The act mandates that each emergency medical services system must:

> include an adequate number of easily accessible emergency medical facilities which are collectively capable of providing services on a continuing basis, which have appropriate non-duplicative and categorized capabilities, which meet appropriate standards relating to capacity, location, personnel, and other health care facilities of the system.

Progress in the development and implementation of a statewide categorization program of hospital emergency capabilities in Pennsylvania is not unlike other areas of the country. Programs have been initiated in the Philadelphia, Pittsburgh and Wilkes-Barre/Scranton areas. However, none of these programs have become fully operational. The recently published "Pennsylvania Comprehensive Plan for Emergency Medical Services" recommends the following:

> There should be an adequate number of easily accessible hospital emergency facilities which are collectively capable of providing a wide range of emergency services on a continuous basis.[4]

In order to provide direction for identifying, stratifying, and linking hospital emergency services throughout the Commonwealth, the plan recommends a classification system based on treatment requirements. The Pennsylvania Medical Society, the Hospital Association of Pennsylvania, and others through the Pennsylvania Emergency Health Services Council have initiated discussions to investigate the feasibility of categorization of hospital emergency capabilities in Pennsylvania.

While the hospital may classify its emergency department according to its capability, the general public does not. In fact, many police, ambulance, fire and rescue personnel do not. The vast majority of hospitals claiming emergency facilities of some kind has promulgated the idea that all hospitals should and are capable of handling all emergencies. Thus, the patient faced with what he or she feels is a life-threatening situation feels it is logical to go to the most convenient hospital. The ambulance service and other public safety services have emphasized rapid delivery of a patient to a hospital and selects the nearest facility. The concern on the part of many is that the majority of emergency service users would be confused by a system that requires a fine distinction to be made between different categories of hospital emergency capabilities. The general public should not be misled into thinking that it is better to delay treatment in order to receive care at a facility the patient thinks is best able to handle his problem. It is for this reason that the process of categorization should be recognized as a tool for the provider to develop a rational and effective emergency medical services system. A program in categorization should involve four steps. First, all hospitals claiming the provision of emergency medical services must be able to perform life support on a continuous basis. The Pennsylvania Comprehensive Plan for Emergency Medical Services recommends that these facilities be staffed and equipped to perform those advanced maneuvers which are required to: (a) prevent cardiac arrest through recognition and correction of life-threatening dysrhythmias; (b) re-establish spontaneous circulation in a clinically dead patient; and (c) prevent vital organ damage from hypoperfusion.[4]

The second step is the provision of special services in a region which are required for the proper care of the critically ill and injured. The following critical patient groups have been identified: (a) trauma and burns; (b) acute cardiac care; (c) poisonings; (d) high risk infants; (e) alcohol detoxification and drug overdose; (f) psychiatric[1]

Critical patients in these categories (except for psychiatric) require immediate advanced life support. Improvements in care can be achieved through a total effort of improved prehospital services, recognition of the severity of these problems at facilities with limited capabilities, and transfer to specialized centers when appropriate. As noted earlier, it is estimated that only 5 percent of the emergency patients require this type of intensive service.

The third step is that the hospital emergency facilities must be linked in a region to provide *the full range* of emergency services required. The capability of each hospital is dependent in part upon what the hospital personnel are involved with at that particular moment. For this reason alone hospitals must coordinate their activities in their region.

The capability of each hospital should be known at all times so that one institution is not forced beyond its capacity because of unusual demand. The fourth and final step is an ongoing review and evaluation of the system. There must be knowledge of the effectiveness of the system and appropriate corrective action when indicated.

Categorization of hospital emergency capabilities is a concept that has undergone a development process since it was first introduced. Today, it offers the provider a technique to improve emergency medical services by identification of basic minimum requirements for life support, identification of specialized facilities for the care and treatment of the critically ill and injured, and the chance to close cooperative relationships between hospitals for the provision of a wide range of emergency medical services in a region. Categorization of hospital emergency capabilities in no way infers inferiority. Instead it represents a medical community effort to provide emergency medical services in an efficient and effective manner. □

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Intensive care

Highest standards for the critically ill and injured

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An estimated 50,000 persons die each year in Pennsylvania as the result of acute medical and surgical problems. About 12,000 of those would not die if emergency medical services (EMS) were ideally organized on regional bases, in a way which would guarantee prompt initiation and continuation of modern advanced life support measures for vital organ failure, i.e., critical care medicine (CCM).[34] Such upgrading would have to include *all* components of the emergency and critical care medicine delivery *system:*[4 15 34]

1. Recognition of the emergency and provision of first aid by bystanders (public education).
2. Initiation of the EMS response system (universal telephone number, highway phones, radios, communications centers).
3. Subsequent treatment at the scene by members of the system (police, firemen, rescuers, ambulance crews).
4. Transportation, with life support (mobile ICU-type ambulances and aircraft ambulances) by members of the system, to the most appropriate hospital facility.
5. Treatment in the hospital emergency department (ED).
6. Treatment in the operating room (anesthesia, surgery).
7. Treatment in the intensive care unit (ICU).
8. Organization and communication for components 1-7.
9. Planning, education, and evaluation of components 1-8.
10. Research (laboratory, patient care, and health care delivery research).

This system is only good as its weakest link. There are several excellent ambulance services and intensive care facilities here and there throughout Western Pennsylvania. But nowhere in Pennsylvania or elsewhere in the United States is there currently a regionally organized EMS system with *all* its components upgraded and coordinated. In western Pennsylvania, in spite of over a decade of time consuming, frustrating efforts by a few professionals[6,24,29,39] only now do we see any evidence that a truly regional EMS System might soon become reality.[10-13,34]

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The following views are based on the author's and colleagues' personal experiences since the 1950s in the development of ICUs, CCM, and regional, state, national, and international recommendations and standards concerning the *triad of critical care medicine*:[38] (a) resuscitation; (b) emergency medical care for life-threatening conditions; and (c) intensive care.

In western Pennsylvania and elsewhere in the United States, the major *obstacles* to upgrading *ambulance services* have been political,[7,35,36,39] namely resistance by providers and opposition by some uninformed, inaccessible members of local governments who have too often been motivated by power politics rather than the potentials of and needs for modern emergency care. At the same time, false pride of some physicians, administrators, and hospital trustees ("there is nothing I or my hospital cannot do as well as any other") has created serious obstacles to regionalization of *hospital* emergency facilities. Finally, full time staffing of EDs and ICUs by staff physicians interested and competent in advanced life support, has been hampered—particularly in major teaching hospitals—by fears among physicians, departments, and disciplines of losing territory.[29,30,37,38] Perhaps surprisingly, bureaucracy, another potential roadblock, has

been only a minor obstacle to EMS developments in the United States. It has been, rather, the fear of some of losing power, prestige, or money that has made voluntary upgrading of all components of the system difficult. If in spite of communications among experts, consumers, providers, and governments (e.g., through EMS community councils) such obstacles continue to retard progress, there is something amiss in the way we govern ourselves. Authoritative, informed decision making is indicated. In some European countries (not only dictatorships but also democracies), for example, better organization of EMS has been achieved, through the authority of governments (health departments) acting upon the advice of EMS boards.[29,34] Throughout the United States, however, including Pennsylvania, health care in general and EMS in particular are disorganized, with the best and worst performances side by side[6,24,28] because "no one is in charge."[42]

Intensive care units

The ICU is the hospital facility to which, ideally, only critically ill or injured patients having a chance to survive are admitted. The concentration of hospitalized, critically ill, and injured patients in ICUs has resulted in lower mortality rates among such patients compared to similar patients scattered throughout the hospital.[34] Mortality is reduced further when these ICUs are staffed around the clock by specially trained physicians. For example, the in-hospital death rate from myocardial infarction was 30 percent before the introduction of coronary care units (CCUs) and is now 10 percent in CCUs with 24 hour physician coverage.[22,34] Similar successes have been achieved in units for critically ill newborn infants[43] and for patients with primary respiratory failure.[23,26] Statistics from one of the four general multidisciplinary medical-surgical ICUs at the University Health Center of Pittsburgh bear this out.[34,38] From 1965 to 1974, the overall ICU mortality remained at 20-24 percent of admissions, while the proportion of critically ill patients increased, as evident from an increase of patients requiring prolonged mechanical ventilation from 20 percent to 75 percent of ICU admissions. As physician coverage has been increased steadily, mortality in patients receiving mechanical ventilation has decreased from 49 to 30 percent. Similar trends were observed in the pediatric ICU.[20]

However, reduction in ICU mortality is not enough. Ideally, those who leave the ICU alive should, for humanistic as well as economic reasons, have the expectation of a quality of life at least acceptable to them. Modern technology has enabled us to sustain vital functions in many who can never be restored to life in a meaningful human sense, and their continued existence then becomes a difficult burden to themselves (if conscious), family, medical staff, and society at large. The increasing tendency to discontinue life support in patients with brain death[17] and to refrain from heroic measures for patients in the terminal stages of incurable disease reflects an attempt to deal with this problem. Better patient selection for admission to intensive care units is also warranted. When ICUs concentrate on caring for patients who have a chance to survive with human mentation, even ICU costs of many thousands of dollars have proven "cost-effective."[5]

We define intensive care as "continuous intensive monitoring and life support, as well as definitive therapy, of patients with critical or acutely life-threatening illness or injury."[33,37,38,40] General (multidisciplinary medical/surgical) ICUs offer economic and patient care advantages over fragmented, departmental or organ-oriented ICUs—particularly for patients with multiple organ failure.[33,34,38,40] For instance, when specialty ICUs in one institution were replaced with a single multidisciplinary unit staffed by CCM physician specialists, mortality from respiratory insufficiency was decreased from 30 percent to 10 percent, and mortality from myocardial infarction from 30 percent to 15 percent (Kassebaum, Portland, Oregon, personal communication).

Specialty ICUs which *are* justified include CCUs for arrhythmia control, neonatal ICUs, general pediatric ICUs, burn units, and spinal cord injury units. In all ICUs, however, advanced respiratory care, arrhythmia control, as well as precise management of fluid and electrolyte balance, acid base status, and alimentation also should be provided. Patients with reversible brain failure may benefit from advanced techniques of monitoring and restoring homeostasis to the brain, an aspect of life support still in a semi-experimental state, which should be provided increasingly in those general ICUs to which comatose patients are admitted.[27,31]

For *ICU design* we favor 6-8 bed ICU clusters, each cluster around one nursing station from which all 6-8 patients can be seen. Each bed should be glass-enclosed for quiet, isolation, or reverse isolation. In large hospitals several such sub-ICUs (medical, surgical, cardiac, intermediate unit, etc.) should be next to each other to form Critical Care Centers,[21,44,45] which can be staffed by a common pool of nurses and physicians. The director of each sub-ICU should be automatic consultant in the other sub-ICUs. In very large medical centers, the number of highly specialized units, some for clinical trials (research), may be too numerous to be accommodated in one critical care center.

We in western Pennsylvania have favored the development of general ICUs over, for instance, pure respiratory care units.[6,11] Almost all patients with acute life-threatening illness or injury have respiratory insufficiency. Furthermore, in most critically ill patients, failure of one organ system quickly leads to failure of others. In most community hospitals, coronary care services are also provided in the general ICU, to avoid costly duplication of facilities and because many patients requiring arrhythmia control also have respiratory failure or other vital organ systems problems.

The CCM (ICU) physician and organization of intensive care

Critical care and emergency care share common goals but differ in depth, scope, and the physicians' clinical base of operation. The clinical base of the CCM physician is the ICU, where presumably all patients are critically ill or injured. The clinical

base of the emergency physician is the ED, where many patients come simply for primary care and fewer than 5 percent of patients are critically ill or injured.[34] While emergency medicine is evolving as a base specialty, CCM is evolving as a subspecialty of anesthesiology, medicine, pediatrics, surgery and emergency medicine with a common body of special knowledge, skills, and attitudes.[3,41] Physicians from both emergency medicine and critical care medicine, however, should work together to foster public awareness of the potentials of a modern emergency and critical care system. Organizations such as the National Federation of Societies for Emergency and Critical Care Medicine (Society of Critical Care Medicine, American College of Emergency Physicians, University Association for Emergency Medical Services) permit specialists from these related disciplines to evolve joint approaches to common problems.[30]

Both the CCM physician and the ED physician should concern themselves with the standards of pre-hospital emergency care and coordination of EMS system components (organization, education, evaluation, research). The involvement of the ICU physician in the development of standards of *all* components of the EMS system is essential, since the most sophisticated life support in ICUs becomes senseless, expensive, terminal care if irreversible vital organ systems failure occurs prior to ICU admission. The CCM physician concerns himself as well with critical cases already in the hospital, such as patients with postoperative complications and others who deteriorate after elective admissions.

Critical care must be titrated care. Therefore intensive care by nurses and respiratory therapists who remain at the bedside while the primary physician merely makes rounds and prescribes may be intensive nursing care but is inadequate for patients who need stabilization for multiple organ failure. Furthermore, in teaching hospitals patient care suffers when inexperienced junior house officers, without guidance by staff skilled in life support, are given authority over the total care of the critically ill or injured patient. The situation is compounded when house staff cannot remain at the patient's bedside because of other duties elsewhere in the hospital.

Application of most modern advances in emergency and longterm resuscitation requires more than an M.D. degree, a specialty board, knowledge of the literature or attendance at postgraduate courses. Physicians engaged in providing or guiding intensive care should possess knowledge, skills, first hand experience, and judgement in resuscitative and life support measures. They should be able to master complex technology to prevent, detect and treat emergencies, have some knowledge of a large variety of pathologic conditions, and be able to organize and teach.[3,34,38,41,44]

Several years ago, when ICUs were still in their infancy, we defined the ICU or CCM physician as "a scientifically trained, highly motivated clinician, who has the action-oriented attitude of the anesthesiologist and surgeon, the thoughtfulness of the internist and pediatrician, the inquisitive data oriented mind of the scientist, and the diplomacy of a United Nations ambassador."[32] While these virtues are certainly desirable, even preparation in several disciplines will not create an expert in all fields. Therefore we are now training ICU directors who are fully qualified in a base specialty, e.g., anesthesiology, internal medicine, pediatrics, surgery or emergency medicine (the last not yet endowed by a specialty board).[38,18] Whatever his base specialty, however, the CCM physician is in a sense a generalist because of his interest in patients with multiple organ failure.

Anesthesiologists and ED physicians are good candidates for further

Acute Contact Dermatitis

Patients with acute contact dermatitis present to emergency departments with some regularity, particularly during warm weather months. In such patients, the findings of vesicles in linear array is the important clinical clue which would lead the clinician to suspect an acute contact allergy. By far the most common antigen involved in these eruptions is the rhus oleoresin found in the ubiquitous poison ivy, poison oak, and poison sumac plants. Mild involvement can be simply treated with cool compresses and a soothing "shake" lotion such as calamine lotion. Systemic antihistamines may also be given. But topical preparations containing antihistamines (e.g. Caladryl), zirconium (e.g. Ziradryl), and caine local anesthetics (e.g. Solarcaine) should be avoided in that these agents are themselves potential sensitizers. Extensive skin involvement is best treated with systemic steroid therapy. The usual starting dose is 50-60 mg of prednisone per day in divided doses. After several days, the dose can be tapered, but it is important that the total course of the corticosteroid therapy span a *two-to-three week* period. If shorter courses are given, a rebound recurrence of the contact dermatitis is likely to occur.

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training in critical care since they do not have office practices and more easily free themselves from their primary activities, such as operating room or ED work. Moreover, anesthesiologists have pioneered resuscitation and intensive care by applying what they have learned in the operating room and recovery room to medicine at large.[32,33] Sophisticated anesthetic management of patients in poor physical status for major surgery *is* critical care medicine.

National recommendations[19,40] call for each ICU to have a full time or "most-time" medical director, not merely an ICU committee chairman. This medical director should be selected on the basis of competence, interest, and availability, not specialty or departmental affiliation. In western Pennsylvania this trend started in the early 1960s and has expanded steadily. Less well developed are mechanisms for providing the help this medical director needs for 24 hour ICU supervision and physician coverage. There should be part time codirectors who also have experience in life support preferably with base specialties different from that of the director.[18,40] In addition, an ICU head nurse should work closely with the medical director. The ICU team includes a great variety of personnel in addition to physicians and nurses.[16]

The smooth functioning of an ICU depends upon organization, well-defined responsibilities and lines of authority, and standardization of certain procedures.[33,34,38] *Responsibilities for medical care* will depend upon local circumstances. Physician authority in the ICU should be spelled out in the ICU policy. CCM must be a multidisciplinary endeavor, crossing traditional departmental and specialty boundaries, since no single physician has all the knowledge and skills required for the management of these critically ill patients.[3,37,40] The multidisciplinary team, however, requires a team coordinator who ensures that patient care is not fragmented, but the many specialists involved are orchestrated, for the benefit of the patient. This is particularly important in cases of severe trauma. Ideally, in physician-staffed ICUs (see later), this coordinator, for the period of ICU care, should be the ICU director and his multidisciplinary staff, through whom all orders should be channelled. The coordinator's chief responsibility should be to provide continuity of life support until transfer to a general care area. He should call on consultants as needed. The primary attending physician or operating surgeon, when not the coordinator, should remain a team member to maintain continuity. All available talents of possible benefit to the patient should be mobilized. The coordinator should be competent in modern life support methods, knowledgeable about the patient's primary pathophysiologic problem, and available at the bedside for guided titrated therapy, either personally or through associates competent in life support, whether staff or senior house officers involved in ICU training.

In most medical/surgical ICUs in the United States, however, the primary attending physician or operating surgeon who admits the patient to the ICU insists on remaining in charge of general care of his patient in the ICU, even if he can provide only treatment by "rounding and prescription." In this case "treatment by titration" should be provided by the ICU director, his associates, and trainees, who should at the least be automatic team members, responsible for respiratory care and other life support measures for all ICU patients.

Experience in other countries, where the ICU director and his staff (usually anesthesiologists) are in charge of general care, suggests that patients benefit from this approach. In the United States the concept of ICU director in charge has received support chiefly in coronary care units, where authority for patient management, for the duration of the patient's CCU stay, automatically falls upon the cardiologist in charge of the CCU. Hospital staffs unwilling to give authority for overall patient management to the ICU physician of a general ICU may do so more readily for the ICU physician of a departmental ICU. In many circumstances, the ICU physician will gain recognition from his peers not simply because of demonstrated competence, but also because of personal night and weekend stands at the bedsides of unstable patients.

For most *community hospitals without house staff*, 24 hour, in-house ICU coverage by physicians experienced in life support has been a major problem and may well be unfeasible. We recommend,therefore, one of two alternative approaches:

1. A competent ICU director could be appointed to see selected cases and, through teaching and quality control, provide most of the high caliber 24 hour ICU services through well trained nurses and respiratory therapists. The ICU director would promptly refer patients requiring long-term advanced life support to a facility with better physician staffing.[14]

2. The ICU director could rely on either anesthesiologists or ED staff physicians with special competence in CCM to provide in-house ICU physician coverage until the patients are transferred. Keeping patients who require advanced intensive medical care in the community hospital is reasonable only if its staff can make the commitment for 24-hour ICU coverage by physician specialists and ancillary personnel.

The *manpower need* for CCM (ICU) physicians is large. There are about 1,400 acute general hospitals with over 200 beds each in the United States today. Given an average need of at least one ICU director and one ICU codirector for each hospital, about 2,800 physicians with special competence in CCM are required. With university hospitals' need for 6-8 ICU physicians each, because of the many specialty units, the total estimated national need is about 3,500. At this time only about 500 physicians have "special competence and interest in CCM" expressed through their membership in the Society of Critical Care Medicine (SCCM). The initiators of intensive care in the 1950s and 60s acquired special competence in CCM primarily through "on the job" experience in addition to their base specialty training. After experience with the organization of the first physician-staffed multidisciplinary ICU in the United States in the late 1950s,[33] this author initiated the first CCM Fellowship Program in the United States at the University of Pittsburgh in 1963.[18,32,38] Other fellowship programs have focused on

specialty intensive care. Since the founding of the Society of Critical Care Medicine in 1971, about 12 CCM physician fellowship training programs have been identified, but few at this time approach the SCCM Physician Education Guidelines.[41] Job opportunities for physicians with special competence in CCM are ample in traditional departments but still few in autonomous, interdisciplinary ICUs.

The SCCM, in cooperation with specialty boards and the National Board of Medical Specialties, is in the process of developing a CCM Fellowship Inspection and Approval System and an examination toward "certification of special competence in CCM," the equivalent of a subspecialty board.[3] Nurses' specialization in intensive care is advancing more rapidly.

The *CCM (ICU) Fellowship Program* at the University Health Center of Pittsburgh has so far trained over 90 physicians, most for one year and some for two years. While in the early years most of the fellows came from anesthesiology, more recently they have come from all major clinical desciplines. The physicians we are trying to develop through this fellowship program should have at least two years of postgraduate training in a base specialty (anesthesiology, medicine, pediatrics, surgery, emergency medicine) and receive additional competence in CCM through experience in general intensive care, administration, and teaching. Selected rotations through CCU, renal unit, neurosciences, neonatal unit, EMS (including mobile ICU) and research, should round out their experience. One year fellows are encouraged to participate in clinical research; two year fellows in full-time laboratory, clinical, or health care delivery research.

Regionalization of intensive care

Through the initiative of physicians, international,[15] national,[1,2,40] state,[24,25] and regional[10-13] organizations have recommended categorization of hospitals into Categories I (most sophisticated) through IV or V (simplest), i.e., *horizontal* (general) categorization; and the establishment of Category I facilities on a regional basis. *Vertical* categorization is for centralized care of patients with special critical conditions, e.g., cardiac emergencies, severe multiple injuries, adult or neonatal respiratory distress syndrome, renal failure, severe burns, spinal cord injury, and those in need of pediatric intensive care.

Certain disease entities require very specialized critical care units, e.g., for assisted circulation, extracorporeal membrane oxygenation, hyperbaric oxygenation, spinal cord cooling or brain homeostasis. *Circular* categorization refers to regional coordination of initial care, sorting, and transport—particularly important in rural areas. While most Category I regional referral hospitals will qualify for Category I in a horizontal and vertical sense for most disease entities, it is conceivable that some hospitals which are "horizontally" Categories II or III may and should qualify "vertically" as Category I for special problems (David Boyd, HEW, personal communication).

A *sine qua non* for regionalization of special care is regional coverage by advanced life support ambulances (mobile ICUs), including aircraft ambulances in some areas to enable prompt transfer with life support under physician command of patients to appropriate facilities within the region.[34,35] The type of ICU available in a facility greatly influences categorization of that hospital for emergency services. For instance, without a Type I ICU, a hospital cannot be a Category I facility. While resuscitative surgery may have to be done in any hospital with an ED, special definitive surgery should be done where there is advanced intensive care.

In any regionalized system of health care, planning is required to determine how many facilities of a given type are required for a given population. The *ICU bed needs* of communities in western Pennsylvania were analyzed. A formula was developed for projected bed needs and results showed about 13 general (medical-surgical) ICU beds needed per 100,000 population. This ratio may be valid for any community:[13]

[Population (e.g., 100,000) TIMES hospital admission rate per year (e.g. 140/1,000) TIMES in-hospital ICU admission rate (e.g. 5 percent) TIMES average ICU stay (e.g. 5 days)] DIVIDED BY [average ICU occupancy rate (e.g. 75 percent) TIMES days per year (365)] EQUALS *13 ICU beds*.

The above includes the rural needs not only for medical-surgical ICU beds but also for CCU beds merely for arrhythmia control of patients with ischemic heart disease, which are included in the ICUs, but not the separate CCUs in the major general hospitals of the cities. The above figure was predicated on the basis of an average 75 percent ICU occupancy rate which we consider optimal, in order that empty beds be available for citically ill or injured emergency patients.

The care of the critically ill or injured until the mid-1960s suffered from an over-emphasis on ICU design and equipment with an under-emphasis on personnel. Long-term life support—designed to allow drugs, surgery or nature a chance to correct the underlying disorder—may require sophisticated equipment such as special ventilators; vascular, intracranial, EKG, EEG and blood gas monitors; renal dialysis apparatus; extracorporeal heart-lung machines; and others. However, this equipment is only as valuable as the competence and sophistication of the personnel using it. On-line, computerized monitoring in intensive care has proved valuable for research but has not yet been proven to reduce mortality, morbidity, personnel needs or costs. The computer, however, may help save lives in the future, when the loop from sensors to therapy can be closed for semi-automation of some life support features, with alarms.

Data on ICUs in *Pennsylvania* are scanty. This author knows only data from *western Pennsylvania*. Under the auspices of the Comprehensive Health Planning B Agency, guidelines for regional EMS organization including EDs,[10] CCUs,[13] neonatal ICUs,[12] and general medical/surgical ICUs[11] have been developed. Emergency and critical care facilities of Allegheny County hospitals were surveyed and categorized in 1969, primarily on the basis of equipment and staffing.[6] In 1973, with the support of the regional medical program, this survey was repeated for all of western Pennsylvania. We learned that meaningful data on performance capabilities of an in-

stitution cannot be obtained from questionnaires, but require personal, extended visits of all hospitals by an experienced physician.[6] Such a survey is starting now under the auspices of the Emergency Medical Services Institute as a requirement for federal EMS funding.

Present categorization of ICUs in southwestern Pennsylvania focuses primarily on the 24 hour in-ICU presence of special personnel:[11] [37]

Type I ICU–Advanced Intensive Medical Care: This requires a full time physician ICU director with special competence in CCM and in-ICU 24 hour coverage by physicians beyond their second year of residency in anesthesiology, medicine/pediatrics, surgery or emergency medicine, trained in resuscitation and advanced life support. All other specialists and subspecialists on call should be available within 20 minutes of notification. ICU nurses and ancillary personnel are required.

Type II ICU–Basic Intensive Medical Care: This requires a full time physician ICU director and in-house (not full-time in ICU), 24-hour coverage by house officers of major clinical disciplines beyond their first postdoctoral year of training or by attending physicians with basic CCM experience. Specialists should be available within 20 minutes of notification. ICU nurses, respiratory therapists, and an anesthesiologist or nurse anesthetist must be available in-house at all times.

Type III ICU–Intensive Nursing Care: This requires life support by ICU nurses and paramedical personnel (primarily respiratory therapists) 24 hours in-ICU; but not in-ICU coverage by physicians. Physicians in other services (e.g., anesthesiology, ED) should be available at all times in-house to respond to emergencies in the ICU. Physicians with expertise in the major clinical disciplines should be available within 20 minutes of notification.

The Category IV Hospital does not need an ICU as it should transfer patients immediately to ICUs in a higher category hospital. Obviously EDs of all hospital categories must provide 24 hour "CPR Advanced Life Support"[1] which is to be distinguished from "Advanced Emergency Care"[15] and "Advanced Medical Intensive Care."[37]

In southwestern Pennsylvania, there has been considerable upgrading of intensive nursing care since the 1960s, and development of an appreciation of intensive medical care by physicians. In the past, transfers of patients with multiple organ failure to university hospital ICUs were often undertaken too late, after vital organ failure had become irreversible. More recently, an increasing proportion of such transfers have been made promptly. This change has taken place because physicians have learned to appreciate that not only lack of special equipment (e.g. artificial kidney) but also inability to commit physician specialists for 24 hour in-ICU coverage limited their hospitals' ability to provide advanced intensive medical care. Such early transfers have resulted in some startling recoveries.

Once the capabilities of the various hospitals in a region have been determined, who will see to it that patients are taken to the nearest *most appropriate hospital*, not just to the nearest hospital or the one most convenient for the physician or the patient's family? In Illinois this has been accomplished for trauma cases, through persuasion by the then EMS state medical director, Dr. D. Boyd, and the existence (but not implementation) of a state law.[9] In western Pennsylvania we have begun to attempt regionalization of special care for all types of critical illness or injury through the Emergency Medical Service Operations Center (EMSOC) which is funded by EMS/HEW and based at the University Health Center of Pittsburgh. EMSOC, which was initiated by the department of anesthesiology/CCM program under the coordination of Dr. Sol Edelstein, is fostering communication between ED and ICU physicians (primarily members in Pennsylvania of the American College of Emergency Physicians and the Society of Critical Care Medicine) at regular mortality/morbidity conferences. These aim more at "where did the *system* fail" than "what went wrong with individualized patient care." EMSOC plans to provide, starting in early 1976, physician supervision for advanced life support ambulance services under the direction of Dr. Nancy Caroline, consultation to physicians and non-physicians, and expedition of transfer of special problem cases to specific centers throughout the region. The future will show whether this voluntary approach to regionalization can work.

The University Health Center of Pittsburgh's CCM program was initiated and is administered by the department of anesthesiology, and is guided by a multidisciplinary faculty committee. The CCM program (since 1974 under the direction of Dr. Ake Grenvik) has helped upgrade emergency and critical care in Pennsylvania since 1963 by providing graduates of the program to exert medical and organizational leadership for EMS developments and to staff various facilities in western Pennsylvania. In addition, the CCM program has furthered the care of the critically ill and injured through the following:

1. Direction and life support coverage of the four general ICUs of the health center hospitals (over 3,000 admissions per year), which function as regional referral units.
2. Education of residents and interns of various disciplines during short-term rotations through the ICUs.
3. Medical students' programs in all four years (including an emergency care course in the first year and ICU, EMS organization, and mobile ICU experiences in the third and fourth years.
4. Postgraduate programs including the annual emergency and CCM symposia each May.
5. One of the first schools for respiratory therapists in the nation, which has trained almost 200 inhalation therapists, most of whom are staffing hospitals in Pennsylvania.
6. Training of ICU and recovery room nurses.
7. Help in the development of national standards for ambulance design and equipment and EMT basic and advanced (paramedic) training, primarily through the Freedom House Enterprise Ambulance Service (now being absorbed by a city-wide police mobile ICU service).
8. A large regional training program

in resuscitation and the management of acute respiratory insufficiency, under funds from the NIH Heart/Lung Institute.

9. Obtaining regional EMS funding including the EMSOC mentioned above.

In addition, research in the laboratory, at the bedside, and in the community provides a continuing stimulus to improvement of patient care. In the past, the anesthesiology department's resuscitation research contributed to the modernization of respiratory and circulatory resuscitation. Since 1970, research inquiries have focused on resuscitation of the brain.[27,31]

The University of Pittsburgh is responsible for staffing and for quality control of care in the six University Health Center hospitals, as well as undergraduate, graduate, and postgraduate medical education throughout western Pennsylvania. So far, the health center hospitals' EDs have been staffed by house officers and governed by committees. We and other faculty members through appropriate committees have recommended, however, the creation of a unified emergency medicine program and an emergency facility for the health center with the appointment of an emergency program medical director. Faculty of this emergency medicine program would collaborate with the ambulatory care program for two-thirds of its ED patients and with the CCM program for 2-5 percent of its ED patients who are in need of resuscitation. All three programs would be multidisciplinary (multidepartmental).

Conclusions

Resuscitation and intensive care have introduced new possibilities into human existence, for no longer need death cut down a human being in his prime or injury needlessly cripple the victim of mischance. However, the most sophisticated life support facilities and techniques are useless without a system to enable their rational implementation. Each component of the emergency care system—from recognition of the emergency by bystanders to care in the ICU—must be critically examined and refashioned to meet the needs of the region. At the same time, the system must not be permitted to become so vast and impersonal that we forget our *raison d'etre*: the individual human being in distress. □

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The role of the Emergency Care Research Institute

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There are four broad elements in an effective Emergency Medical Services (EMS) system.

- **Effective program leadership** which is realistic and exerts good judgement in balancing economic, medical, and social priorities.
- **An informed community** which reinforces a high standard of EMS system performance by demand and support.
- **Trained and competent personnel**—administrative, medical, nursing, and paramedical.
- **A reliable, efficient, and cost-effective EMS technology**, including emergency care facilities, vehicles, communications, and clinical equipment.

Pennsylvania has a unique and valuable EMS resource which addresses itself, primarily, to the latter two elements. It is a resource, curiously enough, which is largely unknown to the Pennsylvanians and the Commonwealth's physicians. The Emergency Care Research Institute (ECRI) in Philadelphia, however, is well known on a national and international level. It has played a significant role in the development and assessment of EMS technology and has trained many health professionals.

The terms "mobile intensive care unit," "mobile life support system," and "areawide emergency medical system," now in common use, were first coined by ECRI. The concept of a central EMS control center and communications network which linked health care facilities, ambulances, and aircraft, and maintained constantly corrected data on bed and critical care unit availability in the region's health care facilities was first advocated by this group in 1965. Its engineering staff developed a Hospital Emergency Command System (HECS) for rapid mobilization of personnel and equipment and control of elevators which made use of the hospital's existing telephone and internal communication systems. Prototype HECS systems were installed and evaluated in three Philadelphia hospitals. ECRI's health care personnel have trained thousands of Pennsylvanians in cardiopulmonary resuscitation at both the instructor and lay levels. It has received more federal grant and contract funds for EMS research than any other civilian institution in the United States.

A MOBILE analytical system uses gas chromatography to confirm accuracy and calibration of anesthesia machines, flowmeters, and vaporizers.

In addition to its EMS role, ECRI has a singular function in improving the safety, efficacy, and cost-effectiveness of health care technology generally through its medical device product evaluation program. It has been responsible for the recall or modification of more medical devices than the FDA. It has the largest biomedical engineering staff, with the exception of the Veterans Administration, in the Western Hemisphere. Through its Health Devices Program, it provides technical consultation to over 2000 health care facilities and agencies around the world. More immediately, in cooperation with the Hospital Association of Pennsylvania, it operates a Shared Clinical Engineering Service which provides a wide range of direct consultation and technical support services to hospitals throughout the Commonwealth.

Dr. Nobel is the director of the Emergency Care Research Institute. One of the Institute's newer programs is the inspection of ambulances and emergency care equipment.

The Emergency Care Research Institute is a nonprofit, tax exempt, operating foundation chartered in Pennsylvania in 1955. It is dedicated to improving patient care through applied research and development, technology assessment, medical equipment evaluation, and teaching. Institute programs emphasize the interdisciplinary application of clinical, engineering, analytical, physical, and social sciences to solve problems in the delivery of health care.

The Institute's full time staff includes physicians, nurses, licensed professional engineers, and specialists in electrical, electronic, biomedical, mechanical, and test engineering, physics, physiology, hospital planning and architecture, as well as supporting administrative and technical personnel. Research and editorial advisory boards add the knowledge and perspectives of over a hundred additional experienced specialists.

ECRI has carefully developed working conditions that maximize scientific objectivity and productivity in pursuit of the public interest. Neither the Institute nor any of its staff members has a direct or indirect financial interest in promoting the sale of any medical device. The Institute and its employees accept no royalties, gifts, finders' fees, or commissions from the medical device industry. Institute employees are not permitted to own stock in the medical device industry or engage in private consulting work.

ECRI's current programs which have an impact on EMS include: Health Devices; ECRI Shared Services; hospital technology, safety, and environmental surveys; health facilities planning and design; and special services.

Statewide EMS technology program

ECRI has just launched a technical assistance program to upgrade the safety, efficacy, and cost-effectiveness of EMS equipment throughout the Commonwealth of Pennsylvania. Clinical engineering teams will visit hospital-based ambulance services, without charge, to check the operating performance and safety of such devices as defibrillators, monitors, oxygen systems, resuscitators, and similar EMS technology. They will also inventory this equipment and furnish a confidential report to the hospital administrator or ambulance service executive on the status of the equipment, together with recommendations for the correction of deficiencies, if any are found. During these site visits, ECRI team members will explain the operation and application of the equipment they are checking if asked to do so by the health care facility or ambulance personnel. Although all hospitals and ambulance services have already been notified of the availability of this technical assistance program, you may request and schedule a free site visit, inspection program, and report by telephoning ECRI at (215) 923-5470.

Health Devices

Health Devices is an information service for health care technology. Its objectives are to improve the effectiveness, safety, and economy of health services by:

- Providing independent, objective judgement for selection, purchase, and use of medical devices, instruments, equipment, and systems.
- Functioning as an information clearinghouse for hazards and deficiencies in medical devices.
- Encouraging the improvement of medical devices through an informed marketplace.

The Health Devices program consists of the following elements:

- A monthly journal, devoid of advertising, which provides comparative evaluations and ratings of brand-named medical equipment, hazard reports and recommendations for dangerous equipment, and inspection and preventive maintenance procedures to meet the requirements of the Joint Commission on Accreditation of Hospitals and other agencies.
- Unlimited letter and telephone consultation service with technical specialists—physicians, nurses, and engineers, who provide personal guidance in purchasing, hazards, inspection, and maintenance.
- One and two day seminars on health care technology presented throughout North America.

Participation in the Health Devices program is on a membership basis, usually through an insitiutional rather than an individual membership. In Pennsylvania most hospitals with over 100 beds are members. This provides consultation privileges and other membership benefits to hospital staff members and employees.

ECRI COMPUTER keeps track of clinical equipment inventories in hospitals, flags inspection and preventive maintenance intervals, and warns of dangers in recalled devices.

ECRI Shared Services

ECRI's shared clinical engineering

WELL EQUIPPED mobile clinical engineering teams inspect EMS equipment in hospitals and ambulances to check its safety and performance.

service provides a variety of technical and consultation services to nonprofit health care facilities throughout the state in concert with the Hospital Association of Pennsylvania and regional hospital associations.

Clinical engineering is the application of engineering and analytical knowledge and related technical skills to controlling and supporting the technology used for patient care. This relatively new field has grown rapidly over the past few years as equipment and systems used in patient care have escalated in cost, complexity, and adverse effects as well as capabilities. More specialized equipment requires parallel specialization and knowledge for safer, economical, and efficient care. This responsibility is being shared increasingly within a team of health professionals which include the clinical engineer.

The general elements of this hospital cooperative include:

- Careful and detailed prepurchase evaluation and selection of clinical equipment to control the choice of equipment and assure that optimum safety, performance, and cost-benefit attributes accrue.
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Alphabet protocol for initial management of trauma victims

PHILIP R. CAROPRESO, M.D.

LEWIS T. PATTERSON, M.D., F.A.C.S.

Harrisburg

A–Airways

B–Bleeding

C–Catheters

D–Determinations

E–Evaluation

F–Fractures

The successful resuscitation of trauma victims in the accident ward is directly dependent upon the skill and speed of the physicians attending to these patients during frequently chaotic situations. At Polyclinic Hospital a simple protocol of sound emergency procedures, which follows the first six letters of the alphabet, has been established to aid physicians in their systematic assessment and initial treatment of trauma victims presenting under the most demanding situations.

A—Airways

It is imperative that the patient has an adequate airway for ventilation. The initial steps in assuring a patent airway is the removal of debris, dentures or broken teeth from the oropharynx. Nasotracheal aspiration of blood and mucus aids in clearing the airway. Elevation of the jaw and traction on the tongue can further open the airway. An oral airway, endotracheal tube, or tracheostomy should be used when indicated. A thoracostomy tube is inserted for hemothorax, pneumothorax, and tension pneumothorax.

A sucking chest wound must be closed quickly—a sterile, airtight dressing is a rapid, simple, and effective method of sealing these wounds. A flail segment can be initially stabilized by hand pressure. Intubation and mechanical ventilatory assistance by a volume-cycle respirator for "internal stabilization" of the flail segment is the treatment of choice. A patient can survive prolonged periods of shock, but only minutes of airway obstruction can be fatal.

B—Bleeding

Serious, obvious hemorrhage should be arrested immediately by the simplest means available. Direct pressure is capable of controlling external hemorrhage. Internal injury with hemorrhage must be suspected in a patient who is in shock. While up to 2000 cc of lactated Ringer's solution can be used for resuscitation, whole blood loss must be replaced with type-specific, cross-matched whole blood.

In truly emergent situations, type-specific, uncrossed matched blood, or type O Rh negative blood can be given. Volume expanders, such as low molecular weight dextran, are avoided because they interfere with subsequent cross matching procedures. In order to "stop the bleeding," which is the key to treatment of hemorrhagic shock, operative intervention is often required, once the source of hemorrhage has been determined.

The authors are in the department of surgery at Polyclinic Hospital, Harrisburg. Dr. Patterson is director of surgery and Dr. Caropreso is resident in surgery.

C—Catheters

A triple catheter regimen is initially employed. A large-bore peripheral IV, placed by either venipuncture, or venisection, is the preferred route of administering parenteral fluids, blood, and medications. While inserting an intravenous catheter, it is expeditious to obtain a large volume (50 cc) of blood, to be used for all laboratory studies. Lactate Ringer's solution is used in trauma patients for initial volume replacement. Monitoring central venous pressure is important in this regard. Once the patient is stabilized, and it becomes possible to use strict, sterile technique, an intracath via the infraclavicular route is inserted into a subclavian vein. A large lumen nasogastric tube is the second catheter of the triple catheter regimen. It

Multiple Trauma and Shock

Think of the abdomen first. **If no external source of blood loss is identified after an episode of major trauma, abdominal visceral injury is the first consideration. Following initial resuscitation with assurance of adequate ventilation, control of external blood loss, and intravenous fluid therapy, careful evaluation of the abdomen is needed. Marked abdominal tenderness, perhaps associated with shoulder pain, indicates peritoneal inflammation due to either blood or intestinal contents. In questionable cases diagnostic peritoneal lavage may be helpful. The lavage should only be considered as positive evidence for injury. A negative lavage however, may be ignored if other signs indicate a need for laparotomy. The control of abdominal injuries should take precedence over definitive care of most neurologic and orthopaedic injuries which may be temporarily stablized during celiotomy. Chest injuries rarely require definitive thoracotomy but major chest and cardiac injuries should be considered prior to laparotomy.**

Elliott M. Badder, M.D.
Assistant Professor of Surgery
Department of Surgery
Hershey

aids in gastrointestinal tract decompression which is advantageous if abdominal surgery is anticipated. An upper gastrointestinal injury with hemorrhage can be uncovered by the aspiration of blood. The third member of the triple catheter regimen is the Foley catheter. Its most critical function is to monitor the urinary output. In the unconscious patient, and in the patient who is unable to micturate, it provides a urine sample, which, if bloody, indicates hemorrhage secondary to an injury of the genitourinary tract.

D—Determinations

All necessary laboratory studies, including complete blood count with differential SMA-6 and SMA-12, serum amylase, urinalysis, type and cross-match for six units of whole blood, should be performed on the blood sample obtained during venipuncture. Arterial blood gases can be drawn and also an electrocardiogram tracing can be made. When the patient's condition permits, radiographs are obtained as indicated. These studies may include skull and cervical spine films, upright and lateral projections of the chest, upright, supine, lateral and decubitus projections of the abdomen, an intravenous pyelogram, and various extremity views. In the appropriate setting, more sophisticated radiologic techniques, such as arteriography and scintiscanning, must be considered. The need for medications can be determined now. Broad spectrum antibiotics and tetanus toxoid are used when they are indicated.

E—Evaluation

The physical examination is repeated. The importance of repeated physical examinations of trauma victims cannot be overemphasized. Careful attention is given to the pattern of the vital signs. All laboratory data and radiographs are closely analyzed. As a clinical impression is refined, further emergency treatment may be instituted. Other diagnostic maneuvers could be required, or laparotomy may be needed.

F—Fractures

Definitive treatment of fractures can be postponed for extended periods until all life threatening emergencies are resolved. Splinting the involved extremity with a clear, plastic airsplint is the best method of immediate immobilization in the interim. Orthopedic injuries are usually of secondary importance unless the blood supply of the extremity is compromised. In such a situation, immediate reduction of the fracture is required. A fracture of the spine, suspected on physical examination, necessitates extremely careful handling of the patient. With fractures of the cervical spine, the head can be immobilized with sandbags until a more definitive means, such as Crutchfield tongs, can be employed.

Conclusion

The first six letters of the alphabet form an outline for the initial emergency evaluation and treatment of trauma victims. Simple and easy to recall even during the most stressful clinical situation, this outline should serve as a guide for all physicians in their successful resuscitation of traumatized patients. □

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(Continued from page 36.)

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Members of the Medical Profession

We are pleased to announce that construction is now in progress on a fourth building in Doctors' Park, a new and progressive medical complex located at 4300 Union Deposit Road in suburban Harrisburg. Present space is fully occupied by established physicians in various specialties. New units will be custom-finished to the specifications of the new tenants. You are invited to visit our complex or inquire for further information at Union Deposit Corporation, 4200 Derry Street, Harrisburg; (717) 564-0832.

obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **William R. Brown,** Philadelphia; University of Pennsylvania School of Medicine, 1906; age 92; died September 3, 1975. His wife and a son survive him.

• **Joseph A. Cammarata,** Pittsburgh; Jefferson Medical College, 1930; age 73; died September 20, 1975. He was former superintendent of Dixmont State Hospital, secretary of the Westmoreland County Medical Society in 1946, and president of the Montour County Medical Society in 1936. His wife and a son survive him.

• **Benjamin S. Konopka,** Scranton; Georgetown University School of Medicine, 1943; age 60; died September 16, 1975. Surviving are his wife, two sons, three daughters, two sisters, and a brother.

• **Ernest W. Logan,** Pittsburgh; University of Pittsburgh School of Medicine, 1920; age 82; died September 20, 1975. His wife, three daughters, and a son, Ernest W. Logan, Jr., M.D., survive him.

• **John F. Whitehill, Jr.,** Lewistown; University of Pittsburgh School of Medicine, 1950; age 55; died September 22, 1975. He was president of the Mifflin-Juniata County Medical Society and the Mifflin-Juniata Heart Association, and served on various committees in the county and State Societies. Surviving are his wife, five daughters, his mother, and a brother.

Benjamin S. Gillespie, Monroeville; Western Reserve University Medical School, 1939; age 65; died September 22, 1975. His wife, two daughters, a son, and two brothers survive him.

Llewellyn D. Griffiths, Scranton; University of Maryland, 1910; age 88; died July 16, 1975. His wife, two sons, a daughter, and a brother survive him.

Lewis M. Johnson, Carthage, North Carolina; University of Pennsylvania School of Medicine, 1929; age 72; died September 9, 1975. His wife, two sons, and a brother survive him.

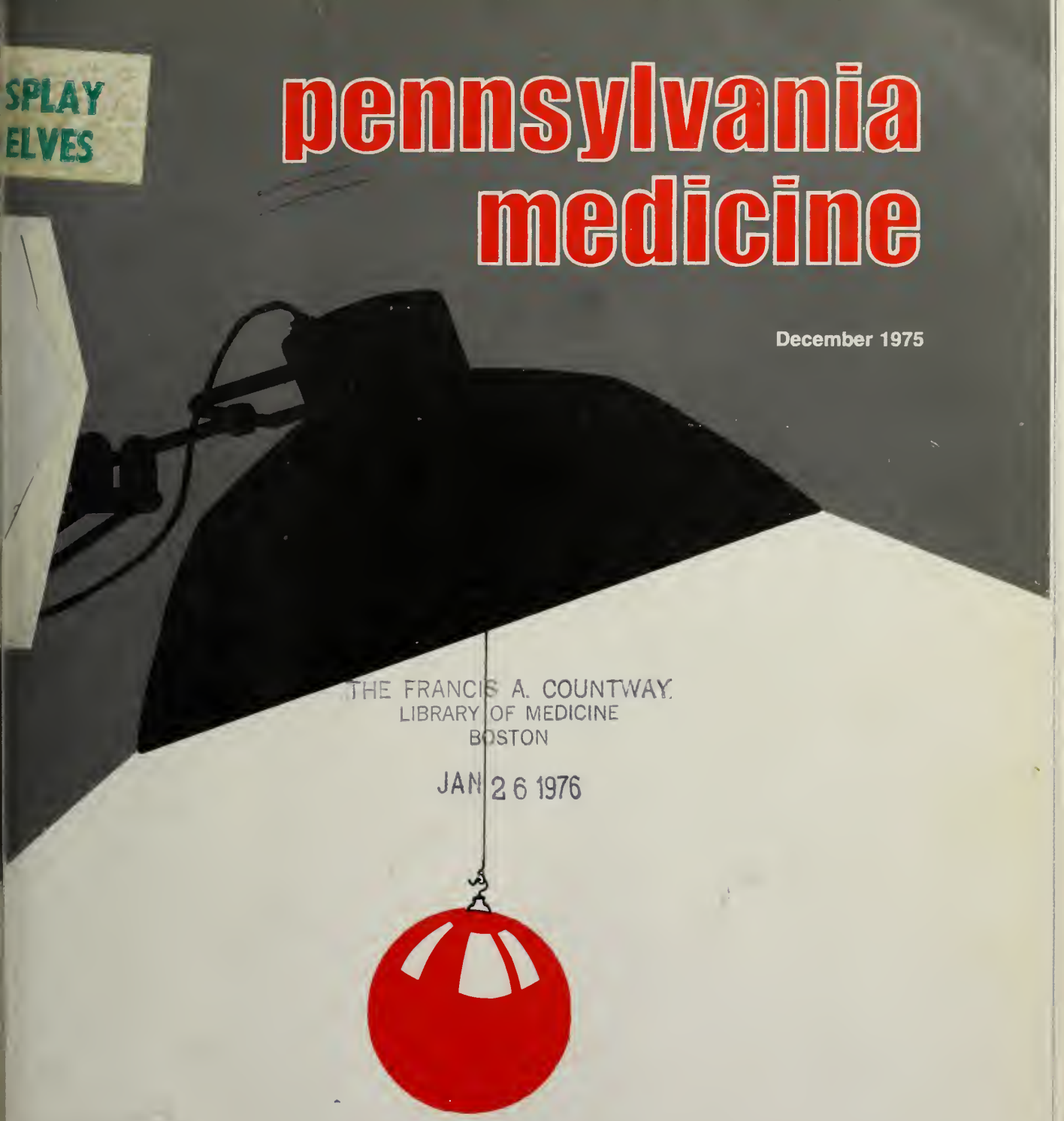
Stephen F. Kratzinger, Jr., Drexel Hill; Jefferson Medical College, 1962; age 38; died September 3, 1975. Surviving are his wife, a son, a daughter, his mother, two brothers and two sisters.

Charles W. Potter, Jr., Weatherly; Jefferson Medical College, 1944; age 55; died September 10, 1975. He was medical director of the Carbon County Home for the Aged and the Weatherly Area School District, and served as medical advisor to the Weatherly Borough Board of Health. Five children and a brother survive him.

Waldo Emerson Preston, Holidaysburg; Medico-Chirurgical College, 1914; age 86, died July 5, 1975. His wife, a daughter, and two brothers survive him.

continuing education

This issue carries no education course listings. The September issue contained a supplement—a comprehensive list of education courses being offered in all parts of Pennsylvania. Consult that issue or write for a copy of the supplement to: Pennsylvania Medical Continuing Education Institute, 20 Erford Rd., Lemoyne, PA 17043.



pennsylvania medicine

December 1975

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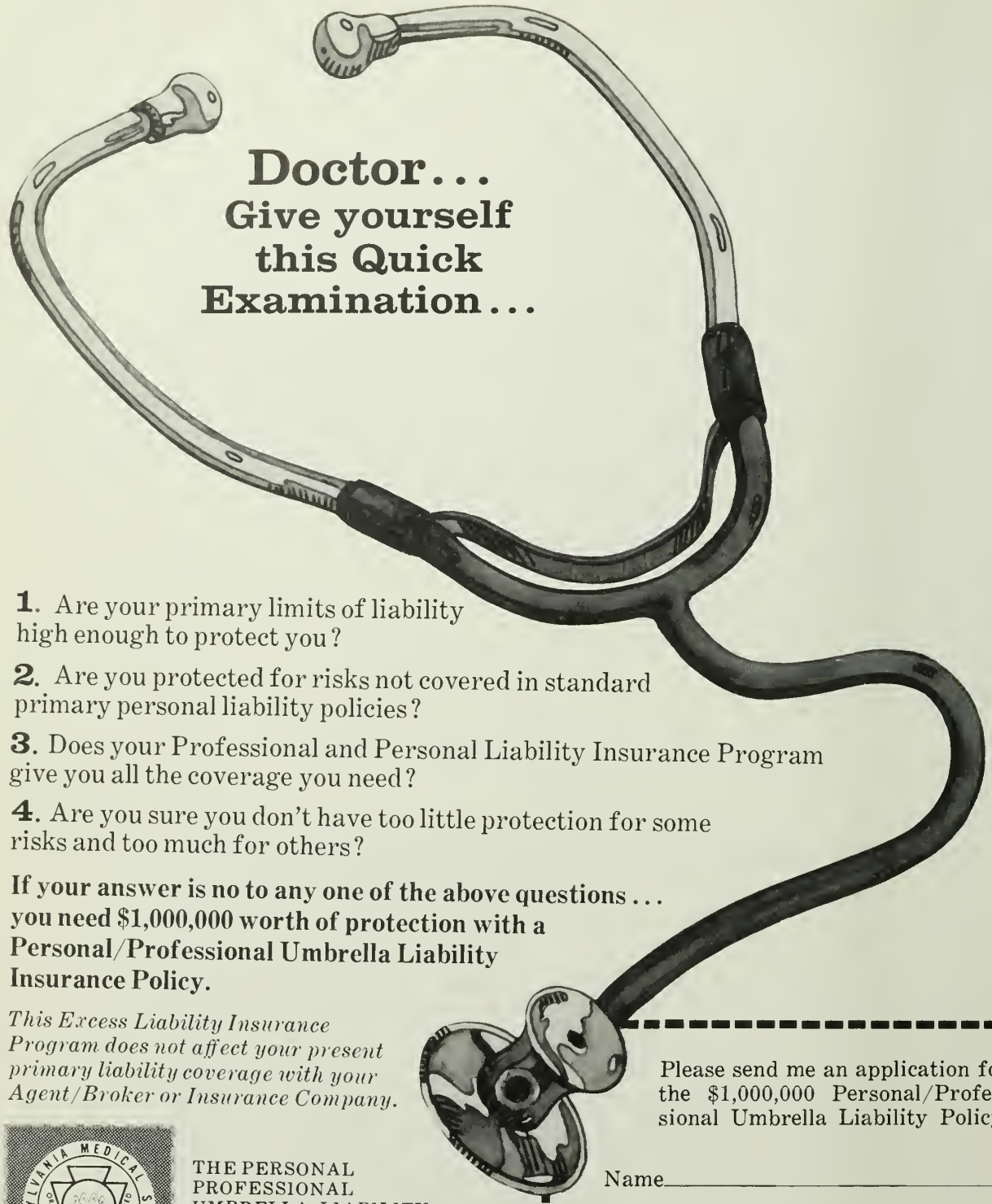
JAN 26 1976

Happy Holidays



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medigram

GOVERNOR APPOINTS ARBITRATION ADMINISTRATOR Paul F. Abrams, of Harrisburg, administrative assistant to the speaker of Pennsylvania's House of Representatives, has been appointed administrator of the Arbitration Panels for Health Care called for in Act 111, the new medical malpractice law. In appointing the 31 year old attorney, Governor Milton J. Shapp said, "Since there is no precedent for a system like this to deal with medical malpractice claims, this position becomes extremely sensitive because the work of the first administrator will make or break the system." Abrams was a principal draftsman of the legislation. The Pennsylvania Medical Society is surveying county medical societies for names of physicians to serve on arbitration panels in order to develop a pool of qualified panel members. The Society will work closely with the administration in the implementation of the new Act. In an article beginning on page 14 of this issue, Fred Speaker, Esq., the Society's legal counsel, comments on the new law.

SOCIETY SUES ON LAB REGULATIONS The Pennsylvania Medical Society on October 14 filed suit in Commonwealth Court to restrain the Pennsylvania Department of Health from implementing regulations for the Clinical Laboratory Act. The rules would have the effect of defining almost all physicians' offices as clinical laboratories, requiring registration, licensing, and surveillance by the department. Although the case is not expected to be heard until early 1976, the Department of Health has agreed not to enforce the regulations pending the hearing. Society President David S. Masland, M.D., has called attention to the regulations in a memorandum to all members of the Legislature. He said "...The purpose of this letter is to acquaint you with administrative problems that have developed over the implementation of the 'Clinical Laboratory Act of 1972.' It has been distorted and misconstrued by administrative regulations. . .When passed in 1972, it was our impression. . .that the bill was designed to tighten up the Department of Health's authority over clinical laboratories otherwise operating without benefit of supervision. It is incomprehensible to us, but, after several meetings with the department, and several sets of proposed regulations, the department continues to suggest that physicians' offices doing routine testing in the course of examining and treating their own patients constitutes practice as a 'clinical laboratory.' We have chosen to take this matter to the Commonwealth Court. . .We thought you should know that once again a law that has been passed and understood by legislators to mean one thing has been distorted by administrators to mean another."

NEW CHILD ABUSE LAW SIGNED Governor Milton J. Shapp has signed into law a bill designed to improve reporting of suspected child abuse cases by giving immunity to persons who report such incidents. The Act also establishes a statewide toll free hotline to report child abuse, and changes the rules of evidence, putting the burden on parents to prove that burns, bruises, fractures, or other injuries are the result of accidents rather than bodily punishment. The State Society and the Auxiliary supported the legislation.

FOUNDATION ELECTS NEW OFFICERS The Pennsylvania Medical Care Foundation elected the following new officers at its meeting November 23: Sidney O. Krasnoff, M.D., Philadelphia, president; Joseph N. Demko, M.D., Dunmore, vice president; and Robert A. Albright, Pittsburgh, secretary. John F. Rinemar executive vice president of the State Society, was reelected treasure Activity in Delaware Chester PSRO Area X, the last PSRO in the Commor wealth to organize, was reported. Earlier in the year the Delaware County Medical Society agreed to the organization of a PSRO Steering Committee and the Chester County Medical Society agreed to participat in the activities of the committee. Articles of incorporation have been filed. The committee's goal is to qualify for a planning contra by January 1, 1976. The Foundation, which serves as the PSRO Support Center in Pennsylvania, is providing administrative and technical assistance. John W. Lawrence, M.D., of Chester, is chairman of the committee.

PHYSICIANS IN TEN COUNTIES TO BE SURVEYED Physicians in ten counties in the Common- wealth can expect a questionnaire from the Governor's Developmental Disabilities Planning Council on services available to persons with developmental disabilities. State Society members are requested to complete the questionnaire which will assist the council to develop a comprehensive inventory of existing services. The pilot counties are Cumberland, Dauphin, Delaware, Erie, Forest, Lackawanna, Luzerne, Perry, Westmoreland, and Wyoming. William Jeffreys, M.D., of Danvil represents the State Society on the Council.

STUDY OF PHYSICIANS' INCOMES 'IRRESPONSIBLE' The State Society termed "irresponsib and misleading" the figures and conclusions contained in a study on doctors' incomes released by Secretary of Health Leonard Bachman, M.D., November 19. State Society President David S. Masland, M.D., said, "The conclusions drawn by the department study are theoretical and in every instance open to serious challenge. Even more alarming are some of the figures used. They just don't make sense. The study claims that Monroe County has the state's highest average physician income, more than three times that of Philadelphia. These figures just can't be right." Dr. Masland also criticized the use of gross income figures rather than net and the obtaining of data from the Pennsylvania Department of Revenue, a serious invasion of privacy.

HEALTH SYSTEMS AGENCIES ACTION CALLED January 17, 1976 is the deadline for filing an application as the Health Systems Agency for each of the nation's 202 Health Service Areas established under P.L. 93-641, the Federal Healt Planning and Resources Development Act. Henry H. Fetterman, M.D., chairman of the Council on Medical Service, has alerted county societ officers to watch for public hearings which must be held in each area prior to filing. Trustees in the Society's 12 councilor districts ar conducting training sessions for liaison officers in each HSA. Dale Yates, Society staff assistant, is coordinating Society involvement, and can be reached at Society Headquarters.

pennsylvania medicine

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Cover design by Jack Schmidt

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PENNSYLVANIA MEDICINE, established in 1897, is published monthly as the official publication of the Pennsylvania Medical Society. All original papers and correspondence should be directed to the Managing Editor. Subscription requests and changes of address should be sent to PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043. A subscription is $5.00 per year. Single issues are 50 cents. Second class postage is paid at Lemoyne, Pennsylvania 17043.

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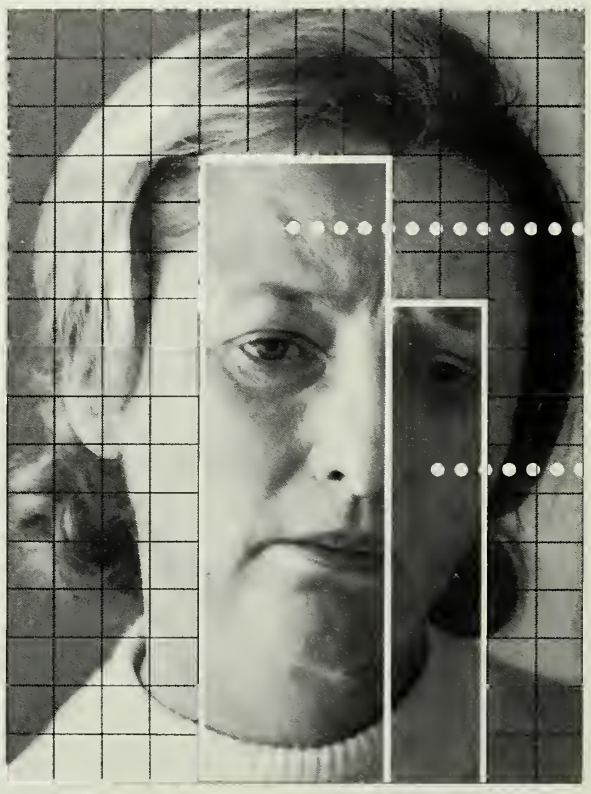

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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According to her major
ymptoms, she is a psychoneu-
otic patient with severe
nxiety. But according to the
escription she gives of her
elings, part of the problem
ay sound like depression.
his is because her problem,
though primarily one of ex-
ssive anxiety, is often accom-
nied by depressive symptom-
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e excessive anxiety is re-
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tic anxiety with secondary
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b ring age, weigh potential benefit
a inst possible hazard.

P cautions: If combined with other psy-
c tropics or anticonvulsants, consider
c efully pharmacology of agents em-
p ved; drugs such as phenothiazines,
n cotics, barbiturates, MAO inhibitors
a other antidepressants may potentiate
it ction. Usual precautions indicated in
p ents severely depressed, or with latent
d ression, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Conference set to explain new malpractice law

A conference to explain Pennsylvania's new medical malpractice legislation, Act 111, will be held on Friday, January 16, 1976, at the Hershey Motor Lodge Convention Center in Hershey, PA. Hours are 9 a.m. to 4:30 p.m. Designed to explain the Act to physicians and surgeons, the conference offers six hours of Category One continuing medical education credit for physicians in attendance.

Sponsors are the Pennsylvania Medical Society, Pennsylvania Bar Association, Pennsylvania State University School of Medicine, and Dickinson Law School.

The following topics have been selected: Overview of Act 111; insurance provisions of the law; disciplinary provisions for the medical profession; legal provisions; and hospital relations under the law. An open discussion will follow the presentations.

Luncheon will be served. For further details contact to Ray Snyder, Continuing Medical Education, Pennsylvania State University School of Medicine, Hershey Medical Center, Hershey, PA 17033. Telephone (717) 534-8898.

Medical Arts '75 successful Society effort

The large audience is attentive at an all day session on the role of the medical director in the skilled nursing facility, chaired by Nathan Sussman, M.D., Harrisburg.

The Pennsylvania Psychiatric Society offered a scientific program on the use and abuse of psychotropic chemicals. Erwin R. Smarr, M.D., education chairman, served as moderator.

Wyeth's autotutors provided a self assessment technique.

MEDICAL ARTS '75, the State Society's new look in educational assemblies, drew large numbers of physicians and other health professionals to the Host Inn, Harrisburg, to attend a variety of educational programs. Above are scenes from the three-day session.

Trust sets record with 1975 student loans

The Educational and Scientific Trust of the Pennsylvania Medical Society reports that, as of October 21, 1975, a record number of 373 medical student loan applications were considered by the Committee on Aid to Education—approximately 35 percent more applications than 1974.

Because of the continually rising costs of medical education and the loan forgiveness provisions of the Comprehensive Health Manpower Training Act of 1971, borrowers from the trust have entered practices in designated shortage areas over the past two years. According to Alex H. Stewart, executive director and secretary of the trust, physicians have entered practices in northern Cambria County and the Burgettstown Medical Service area of Washington County, as well as Clearfield, Huntingdon, Indiana, Jefferson, Perry, and Potter Counties, all shortage areas for many years.

Assets for the trust total $1,790,574, including $1,442,298 in outstanding loans to 891 students. During the year $226,250 in aid was granted to 179 students. Contributions to the trust totaled $146,304, $88,002 of which came from Society membership.

Auto insurance plan ends

Bertholon-Rowland Agencies, which administers certain of the group insurance policies of the Pennsylvania Medical Society, has informed the Society that the EPIC Automobile Insurance Program, a group plan of Aetna Life and Casualty Co., has been scheduled for phasing out nationally effective April 30, 1976.

Society members who converted to the program will be offered the opportunity to convert to one of the regular Aetna automobile insurance policies on a guaranteed basis, provided application is made prior to April 30, 1976. Members may also elect to continue the EPIC arrangement until that date, but at that time would not have the guaranteed replacement privilege.

Each member now in the EPIC program will receive individual notice of Aetna's intent to terminate ninety days prior to the effective date. The company cited underwriting losses nationally in its group automobile insurance plan as the reason for the action.

Cancer Committee elects officers

The Pennsylvania Cancer Coordinating Committee elected as chairman Robert C. Eyerly, M.D., Geisinger Medical Center, Danville, and Hugh R. Gilmore, Jr., M.D., Pennsylvania Department of Health, as secretary, at the organization's recent annual meeting.

The committee, composed of representatives from various medical organizations in the state, seeks to promote reduction in cancer mortality by promoting preventive measures and early detection. Conclusions of the coordinating committee were: (1) that cancer of the lung is one of the leading causes of cancer deaths and that many of these deaths could be prevented by eliminating cigarette smoking; (2) that all women admitted to hospitals should undergo a Pap smear, regardless of the reason for admittance, as the test, which many women have never had, will detect cancer of the cervix in the curable stage; and (3) that cancer of the colon is another common cancer in both men and women and can be detected in the early stages by tests for blood in the stool and by proctosigmoidoscopy.

Members of the Pennsylvania Cancer Coordinating Committee include: the Pennsylvania and Philadelphia Divisions of the American Cancer Society, the Pennsylvania Dental Association, the Pennsylvania Department of Health, the Pennsylvania Osteopathic Medical Association, the Wainwright Tumor Clinic Association, the Pennsylvania Veterinary Medical Association, the Western Pennsylvania Regional Medical Program, the Pennsylvania Liaison Fellows of the American College of Surgeons, and the Pennsylvania Medical Society.

York County physicians honored for recruitment

The State Society's pilot Ambassador Membership Recruitment Campaign was featured at the November meeting of the York County Medical Society. Physicians of the county who served as ambassadors and personally contacted 18 nonmember physicians received lapel pins from Raymond C. Grandon, M.D., Fifth District trustee and councilor.

Thaddeus Lakewa, M.D., president of the York County Medical Society, welcomed ambassadors and prospective members, and Dr. Grandon honored the following members by presenting the ambassador pins: Lawrence C. Fisher, M.D.; Benjamin A. Hoover, II, M.D.; Charles L. Morreels, Jr., M.D.; William F. Shue, M.D.; James R. Smolko, M.D.; Donald B. Spangler, M.D.; John P. Whiteley, M.D.; William C. Yohe, M.D.; and Dr. Lekawa.

Of the 18 prospective members contacted, 14 agreed to become members.

Society Bicentennial project needs support

Rush House groundbreaking sparks fund raising drive

Groundbreaking ceremonies for the restoration of the Benjamin Rush House were held recently on the grounds of the Philadelphia State Hospital at Byberry. Robert E. Jones, M.D., chairman of the restoration committee and clinical director of the Institute of Pennsylvania Hospital, officiated at the ceremonies. Franklyn Clarke, M.D., superintendent of the Philadelphia State Hospital, and Daniel Blain, M.D., former superintendent, assisted Dr. Jones. Donald Cooper, M.D., First District Trustee, represented the State Society. Citizens of northeast Philadelphia and representatives of about thirty local organizations joined in the groundbreaking.

The restored house will be a focal point for the planned Benjamin Rush State Park, a bill for which has passed the Senate and is now under consideration by the House of Representatives. The restoration committee hopes that the house will be completed and the bill, sponsored by Senators H. Craig Lewis and Louis Hill, will pass in time for the Bicentennial.

Physicians are urged to write to their State Representatives in order to expedite passage of the bill.

CITIZENS of Northeast Philadelphia demonstrated their solid backing of the Benjamin Rush House reconstruction and the creation of Benjamin Rush State Park by turning out in force at the groundbreaking this fall. The State Society adopted the reconstruction of the Rush birthplace as its official Bicentennial project and is still accepting contributions, since the Rush House Committee is seeking funds to complete the project in time for the 1976 Bicentennial. Contributions may be sent to Society Headquarters, and are tax deductible.

Enclosed is my tax free contribution for the restoration of the Benjamin Rush birthplace.
Please make check payable to the Pennsylvania Medical Society

NAME _____

ADDRESS _____

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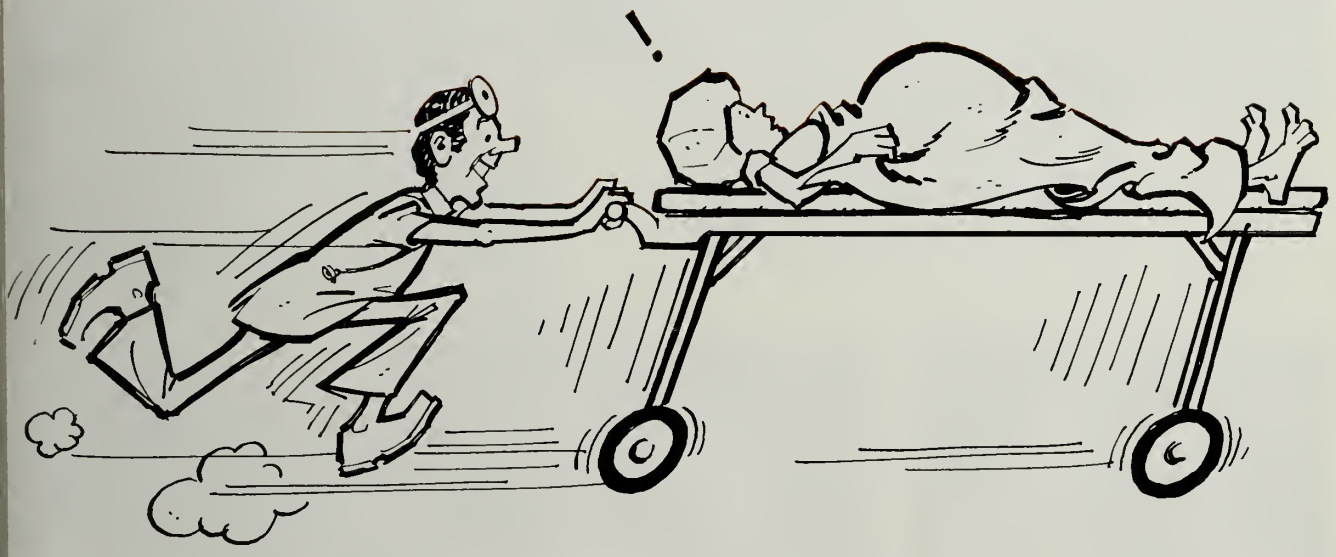
We Deliver!



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Auxiliary has new name, membership goals

A NEW NAME, Pennsylvania Medical Society Auxiliary, required a constitutional change when the Woman's Auxiliary to the Pennsylvania Medical Society met in October in Lancaster. The name change was adopted along with the changing of the word "wife" to "spouse" in the constitution so that husbands of physicians could be accepted for membership. The organization also established a junior associate membership for spouses of medical students, interns, and residents. The photographs on this page show scenes from the Auxiliary's 1975 convention.

IN RECOGNITION of International Women's Year and Auxiliary participation in legislative activities, Shirley Pettis, member of the U.S. House of Representatives from the 38th District of California, was featured speaker. Mrs. Donald Harrop, legislative chairman; Shirley Pettis; Mrs. Raymond C. Grandon, 1974-75 president; and Mrs. Richard T. Smith, 1975-76 president are left to right above.

THE FOUNDER'S AWARD was presented to Mrs. Robert F. Beckley of Clinton County, who served as president of the State Auxiliary in 1963-64 and president of the AMA Auxiliary in 1972-73. The Founder's Award is the highest citation the Auxiliary bestows on a member for service in their community and to the medical profession. Mrs. Grandon, Mrs. Beckley, and Mrs. Frederick R. Gilmore, chairman of the Founder's Award Committee, are shown left to right above.

HONORARY MEMBERSHIP was conferred upon Mrs. C. Henry Bloom, left, of Blair County, by Mrs. Grandon. By precedent, the Pennsylvania Auxiliary confers honorary membership on a member who has earned this citation by years of distinguished service but who has not been its president.

GUEST SPEAKERS included Malcolm C. Todd, M.D., immediate past president of the American Medical Association; and Mrs. Erle E. Wilkinson, president of the American Medical Association Auxiliary. Dr. Todd, Mrs. Smith, Mrs. Wilkinson, and Mrs. Grandon are left to right above.

THE ANNUAL joint meeting of the Montgomery County Medical Society and the Montgomery County Bar Association concentrated on the malpractice crisis at its recent meeting in Whitemarsh. Max H. Parrott, M.D., president of the AMA, principal speaker, had as his topic, "Doctors and Lawyers; we're specialized, but are we civilized?" Shown above, left to right, are David S. Masland, M.D., president of the State Society; Alan L. Dorian, M.D., president elect of the Montgomery County Medical Society; Irwin Benjamin, Esq., president of the Pennsylvania Bar Association; and Dr. Parrott.

Co-op completes first two months in operation

OCTOBER was the first full month of operation for the Pennsylvania Medical Cooperative. Co-op manager Jack Hogan reported more than 16,000 pounds of supplies were shipped to co-op members in filling orders from an inventory of more than 250 items. Twenty-four hour turn around time in filling orders enabled most co-op members to have their supplies within two to three days. Hogan said another 150 items are scheduled to be added to the inventory this month.

Pathology college offers monitoring

The Society Board of Trustees has endorsed PEP, the Proficiency Evaluation Program for office laboratories which was developed by the College of American Pathologists to assist physicians in private practice in the improvement of the quality of their office laboratories.

PEP is a relatively inexpensive system for monitoring an office laboratory and offers benefits such as: an outside quality control check on the results of laboratory systems; peer evaluation with other physician office laboratories, using the same methods, instruments, and reagents; a check on possible sources of error; and a listing of consultants to help resolve technical or procedural problems.

To participate in PEP, physicians send a subscription form and a fee which pays for one year's subscription. Then PEP will send eight specimen kits during the year. The results of each physician's laboratory will be compared to those of other physicians' laboratories in each discipline.

PEP offers continuing medical education credits on an hour for hour basis in Category I when the physician has participated throughout the program and carried out any required changes as a result of the findings of the program. Physicians may claim one to five hours of credit.

For further information write the College of American Pathologists, 7400 North Skokie Boulevard, Skokie, Illinois 60076.

Eighth district trustee honored in Fairview

The Community Council of Fairview recently held a reception in honor of David J. Keck, M.D., trustee of the Eighth Councilor District and chairman of the Publication Committee, for his 25 years as the community's family physician. Dr. Keck's family, members of the original community council who in 1950 decided to find a doctor for Fairview, and many other of his long time friends attended the reception to express their appreciation for his dedication over the years.

In addition to his regular practice and activities as a Society board member, Dr. Keck is medical director of the Erie County Hospital and chief of the division for alcoholism at the St. Vincent Health Center where alcoholics receive initial treatment.

Opinion & Dialogue

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration

Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

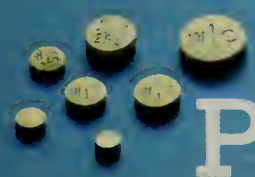
I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

Improving on nature... from the rough, uncut stone to the finished gem



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Devoid of any glandular debris.

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Standardized chemically, biologically, and (at intervals) clinically, for consistent metabolic activity from batch to batch.

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It all adds up to natural thyroid with the added improvements of man.

Please see adjoining column for brief summary of prescribing information.

EDUCATIONAL SYMPOSIUM

Pittsburgh , Pennsylvania

January 16-17, 1976

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LOCATION

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COURSE DESCRIPTION

You are cordially invited to attend a two-day symposium whose major goals are:

- To share with you our plans to prepare a physicians handbook on "The Cardiorespiratory Diseases of Coal Workers".
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While there will not be a registration fee for this course, registration will be limited to 50 participants. If you wish to participate we urge you to act now. Complete and return the coupon below or call the American College of Chest Physicians at (312) 698-2200.

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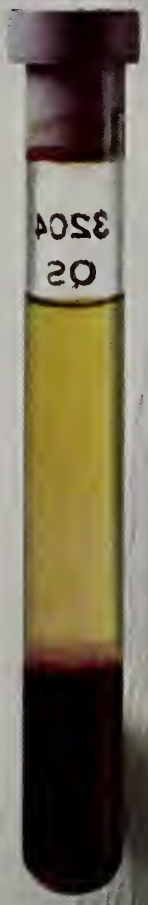

*Choloxin®
(sodium dextrothyroxine)

agent for low density lipoproteins, "type II hyperlipidemia," in euthyroid, non-cardiac patients.

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DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

See reverse side for full prescribing information

Choloxin® (sodium dextrothyroxine)

The Lipid-Lowering Agent with Once-A-Day Dosage

Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following:
Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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Deerfield, Illinois 60015

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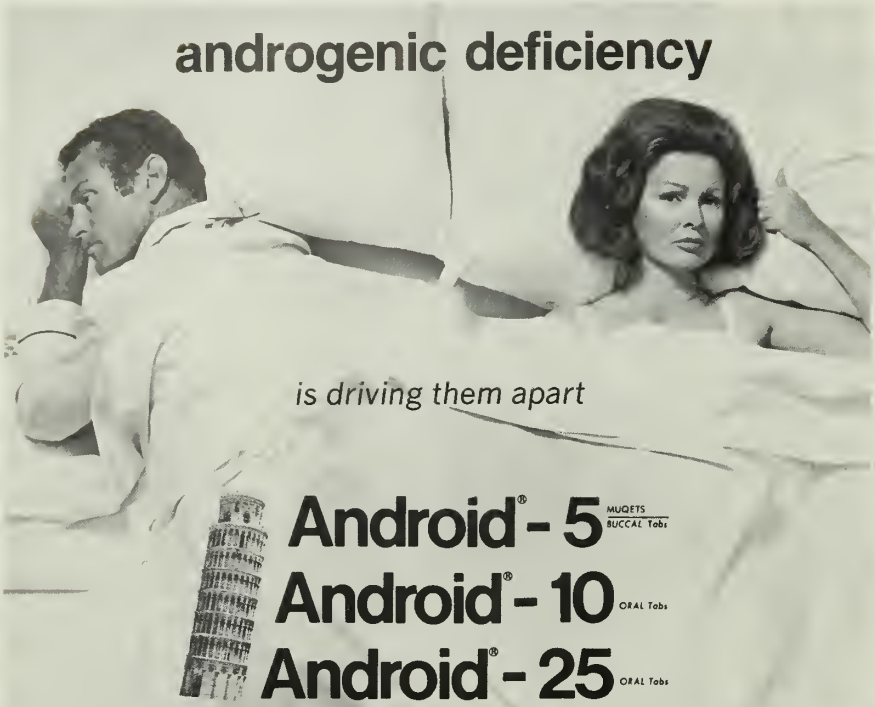

is driving them apart

Android®-5 MUQETS BUCCAL Tabs

Android®-10 ORAL Tabs

Android®-25 ORAL Tabs

Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

REFER TO PDR

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Anabolic Stimulant
Increased Muscular Tone
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EACH ANDROID-G TABLET CONTAINS:

Ethinyl Estradiol	0.005 mg
Methyltestosterone	1.25 mg
L-lysine	100 mg
Nicotinic Acid	12.5 mg
Iron (from Ferrous Sulfate)	2.82 mg
Vitamin A	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg
Riboflavin	2.5 mg
Ascorbic Acid	25.0 mg
Folic Acid	0.1 mg
Vitamin B-12	1.5 mcg
Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide	0.075 mg
Calcium (from Dicalcium Phosphate	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 mg
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg

ACTION AND USES — DOSAGE: 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets. Rx only.

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BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
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Practical Management Of Reproductive Problems In Men And Women

February 4 and 5, 1976

The Hershey Motor Lodge and Convention Center
Hershey, Pennsylvania

FEE: $75.00

Purpose: The purpose of this symposium is to update your information on new developments in the understanding of reproductive processes and to outline approaches to management of patients with reproductive problems. These sessions will be aimed at the physicians who treat patients with reproductive problems including family physicians, internists, obstetricians and gynecologists, urologists and endocrinologists. Our emphasis will be on practical management. To accomplish this goal, six workshop consultation sessions will be held in addition to formal topic-oriented presentations.

Sponsorship: This program has been sponsored by the Division of Endocrinology of the Department of Medicine and the Office of Continuing Medical Education at The Milton S. Hershey Medical Center, The Pennsylvania State University.

Credit: This program is acceptable for 13 hours of Category I Credit toward the American Medical Association Physician's Recognition Award.

Registration Information: Contact the Continuing Medical Education Office of The Milton S. Hershey Medical Center, The Pennsylvania State University, Hershey, Pennsylvania, 17033. Phone: (717) 534-8898.

MDs in the news

Cyril H. Wecht, M.D., was recently elected vice president of the International Academy of Legal Medicine and Social Medicine. Dr. Wecht is Allegheny County coroner and the director of the Pittsburgh Institute of Legal Medicine. He is on the faculty of the University of Pittsburgh's schools of medicine, dental medicine, and public health, and Duquesne University's schools of law and pharmacy.

Dean W. Roberts, M.D., was recently named chairman of the department of community medicine and environmental health at Hahnemann Medical College and Hospital, Philadelphia. He has been acting director since 1974 and associate dean of the medical college since 1973.

DR. ROBERTS

DR. DEREZIN

The Delaware Valley Society for Gastrointestinal Endoscopy, a newly formed chapter of the American Society for Gastrointestinal Endoscopy, recently elected **Marvin Derezin, M.D.**, Wyncote, as the first president. Dr. Derezin is associate professor of medicine in the division of gastroenterology and head of the section of gastrointestinal endoscopy at Hahnemann Medical College and Hospital. Other officers are: **Norman Cohen, M.D.**, Wyndmoor, vice president; **Julius Deren, M.D.**, Cherry Hill, secretary; and **Anibal Herrera, M.D.**, Springfield, treasurer. The purpose of the society is to help physicians keep pace with continuing proliferation of new information in techniques and equipment.

Groundbreaking ceremonies were held recently for the Dr. David W. Kistler Elementary School, Wilkes-Barre. The school bears the name of **David W. Kistler, M.D.**, in honor of his contributions to the educational and health needs of the community. Dr. Kistler is past president of the Wilkes-Barre Area Board of Education and a former director of the Luzerne County Cancer Society. He is a member of the Society's Council on Education and Science and the Commission on Accreditation.

Richard C. Lyons, M.D., Erie, was recently elected to the board of governors of the American College of Surgeons at the organization's annual clinical conference in San Francisco. Dr. Lyons is vice chairman of the State Board of Medical Education and Licensure.

James H. Robinson, M.D., was recently appointed associate dean and director of minority affairs at Jefferson Medical College, Thomas Jefferson University. Dr. Robinson is clinical associate professor of surgery at Jefferson. A diplomate of the American Board of Surgery and the National Board of Medical Examiners, he is a fellow of the American College of Surgeons and the Philadelphia College of Physicians.

Donald F. Leon, M.D., and **Frances L. Drew, M.D.**, were recently appointed associate deans of the University of Pittsburgh School of Medicine. Dr. Leon, associate professor of medicine and vice chairman of the department of medicine, assists the dean in all areas of his responsibility. Dr. Drew, clinical professor of community medicine, is associate dean for student affairs.

The Hahnemann Medical College Library was recently dedicated to the memory of **Warren H. Fake, M.D.**, of the graduating class of 1927. The dedication plaque was unveiled by Dr. Fake's lifelong friend, **Charles Hollis, M.D.**, professor emeritus of otolaryngology and a member of the board of trustees at Hahnemann.

The Clinical Research Institute of Montreal recently honored **Karl H. Beyer, Jr., M.D.**, as a major contributor to modern pharmacology. The award ceremony, which also celebrated the expansion of the institute and its pharmacology clinic, included the unveiling of a mural showing Dr. Beyer as the discoverer of the thiazide compounds. He is also responsible for the development of drugs such as Benemid and Furosemide. Dr. Beyer is visiting professor of pharmacology at Pennsylvania State University, a lecturer in physiology at Jefferson Medical College, and a lecturer in pharmacology at Temple University Medical School, The Graduate Medical School of the University of Pennsylvania, and the Medical College of Pennsylvania.

Samuel E. McLinn, M.D., Harrisburg, received an award for his scientific exhibit, "Cephradine in Otitis Media," presented at the annual scientific assembly of the American Academy of Family Physicians held recently in Chicago. Dr. McLinn's exhibit was among 105 displayed at the assembly. Evaluation was based on value to family practice, general medical education value, appearance, format, and content.

John Silverio, M.D., Berwyn, was recently elected a member of the committee to the section on pediatric pharmacology of the American Academy of Pediatrics.

Stephen T. Olin, M.D., recently received a certificate in family practice from the American Academy of Family Physicians at a recent meeting of the organization's Lancaster County Chapter. He is a third year resident at Lancaster General Hospital.

Edward A. Nardell, M.D., Wilkes-Barre, **Arthur H. Popkave, M.D.**, Pottsville, and **Soli Tavario, M.D.**, Pottsville, were recently certified in internal medicine by the American Board of Internal Medicine.

The Pittsburgh Psychoanalytic Institute and the Pittsburgh Psychoanalytic Society recently honored **Charlotte G. Babcock, M.D.**, by inaugurating an annual seminar series named for her. The organizations recognized Dr. Babcock for her role in helping to establish the Institute and as a pioneer in the field of psychoanalysis. The First Annual Babcock Symposium was entitled "Parent and Sibling Loss and its Effects on the Clinical Course of Psychoanalytic Psychotherapy." Dr. Babcock is professor of psychiatry at the University of Pittsburgh School of Medicine.

The American College of Surgeons recently named the following physicians as fellows: **Thomas Logio, M.D.**, Kane; **Ralph F. Himes, Jr., M.D.**, and **Dennis Gordon Youshaw, M.D.**, Altoona; **Ranganatha Soundararajan, M.D.**, and **Soo W. Hong, M.D.**, Williamsport; **Thomas L. Bauer, M.D., J. Joseph Danyo, M.D., Robert M. Davis, M.D.**, and **John W. Tull, M.D.**, of York.

Charles P. Van Tilburg, M.D., Franklin, was recently named a special consultant to Governor Milton J. Shapp on the National Health Planning and Resources Development Act. Dr. Van Tilburg is a specialist in pediatrics and adolescent medicine and chairperson of the pediatric care task force of the Comprehensive Health Planning Council of Northwestern Pennsylvania.

John W. Eiman, M.D., has been elected for a three year term to the board of directors of the American Society of Clinical Pathologists. Dr. Eiman is pathologist in chief of Abington Memorial Hospital laboratories.

Baldev Singh, M.D., was recently named a fellow of the American College of Anesthesiologists. He is acting director of anesthesiology at Altoona Hospital.

Robert G. Timmons, M.D., Erie, was recently named director of the premedical phase of the family practice program of Gannon College operating in conjunction with Hahnemann Medical College and Hospital. Dr. Timmons is chief of the Division of Infectious Diseases and director of medical education at Hamot Medical Center.

Matthew T. Moore, M.D., presented a paper entitled "Non-Surgical Management of Intracranial Meningiomas," at the Fourth Pan-American Congress of Neurology held recently in Mexico City. Dr. Moore is emeritus professor of neuropathology at the University of Pennsylvania School of Medicine.

Robert J. Hudson, M.D., was recently appointed superintendent of Torrance State Hospital, Torrance. Before assuming his present position he had been chief of the psychiatry service for the Veterans Administration Hospital in Waco, Texas.

The latest edition of the widely distributed text, *Current Diagnosis*, includes a chapter on "Hydronephrosis," written especially for the text, by **John W. Best, M.D.**, York. Dr. Best, a urologist at York Hospital, is a past president of the York County Medical Society, Central Pennsylvania Chapter of the American College of Surgeons, and the Urological Association of Pennsylvania.

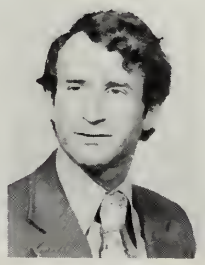
Gerhard Werner, M.D., recently became vice president for professional affairs at the University Health Center of Pittsburgh. Dr. Werner is dean of the University of Pittsburgh School of Medicine, and a pioneer in research on electrical impulses of the brain and information processing of the nervous system.

J. Martin Myers, M.D., was recently appointed to the Accreditation Council for Psychiatric Facilities of the Joint Commission on Accreditation of Hospitals. Dr. Myers, psychiatrist in chief of The Institute of Pennsylvania Hospital, will serve a three year term which begins January 1.

Robert L. Lavine, M.D., was recently named assistant professor of medicine and diabetologist in the division of endocrinology and metabolism at Hahnemann Medical College and Hospital. Previously, Dr. Lavine was consultant to the Adolescent Clinic in Diabetes at The Children's Hospital in Washington, D.C.

The following physicians were named fellows of the American Academy of Family Physicians during the organization's recent scientific assembly in Chicago: **William O. Fulton, M.D.**, Stewartstown; **Harry H. Hunter, M.D.**, Phoenixville; **John E. Nemec, M.D.**, Irwin; **Stuart W. Dittmar, M.D.**, **Gordon P. Van Buskirk, M.D.**, and **David M. Rahauser, M.D.**, Chambersburg.

Elliot Cooperman, M.D., was recently named associate director of the Young Adult Program, specializing in the treatment of patients 18 to 25 years old, at the Institute of Pennsylvania Hospital. Dr. Cooperman was a member of the first graduating class of the combined B.S.-M.D. five year program of The Pennsylvania State University and Jefferson Medical College.



DR. COOPERMAN

DR. SCHREIBER

Alan D. Schreiber, M.D., was recently named a Leukemia Scholar by the Leukemia Society of America. Dr. Schreiber is a hematologist at the Hospital of the University of Pennsylvania, and assistant professor of medicine in the university's school of medicine.

David M. Goodner, M.D., director of the perinatal unit at Temple University Health Sciences Center, delivered the second annual Charles K. Fetterhoff Memorial Lecture at a recent meeting of the Central Pennsylvania Gynecological Society held at Harrisburg Hospital. Dr. Goodner's lecture was entitled "Genetics for the Obstetrician-Gynecologist." The lecture was established to honor **Charles K. Fetterhoff, M.D.**, who was chairman of Harrisburg Hospital's department of obstetrics and gynecology from 1960-1974.

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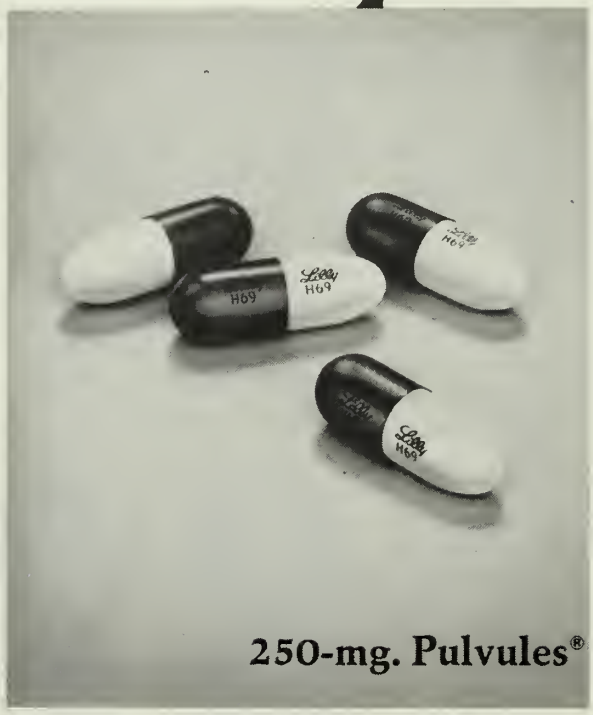

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editorials

TV medicine and other fairy tales

The number of medical programs available for the American television audience to view has mushroomed since the initial success of *Marcus Welby, M.D.*, a few years ago. If the quasi-medical *Emergency!* can be included in this group, we are treated to no less than five programs per week, Sunday and Friday being the exceptions. Although all have some rudimentary elements of fact, they are overwhelmingly simplistic and unlifelike.

In almost all cases the physician assumes a rather glorified posture. He is portrayed as a man who knows and does all and has infinite patience and understanding. He can spend as much time as necessary—days even—with one patient. As a general practitioner, he can do major surgery. When a procedure is beyond his scope, he feels that he has somehow let the patient down, having followed him this far and now unable to do more. Conversely, no matter how specialized the physician is, he may be seen performing the simplest of tasks.

Communication on all levels involving the physician is unreal. Again, time is a factor. Television doctors seem to have time to discuss cases in lengthy detail with the patient as well as other physicians and nurses who are engaged in the medical care of one individual. The office nurse and her interaction with both the physician and patient is so ideal that one wonders whether she ever stops smiling or sits down.

Medical programs, comparable to "I Am Joe's . . ." of the *Readers Digest,* talk primarily to the public and herein lies both their strength and weakness. They may alert the lay audience to symptoms of diseases not otherwise known about. Several years ago a group of medical students wrote a letter to *Annals of Internal Medicine* praising a program which had drawn their attention to the little known entity of familial periodic paralysis. However, it should also be noted that chronic complainers can pick up interesting symptoms from television cases.

One of the newest program additions to the medical scene is NBC's *Medical Story*. Iconoclastic compared to other television productions, it deals with such topics as malpractice, suicide, unnecessary surgery, and hospital bureaucracy. If earlier medical programs erred in favor of the physician, the neophytes this fall tend to err to the other end of the spectrum. No profession is either entirely good or entirely bad, but to parade the bad and the ugly across the television screen benefits no one. It unnecessarily slurs the image of medicine while ignoring the internal checks and policing, peer review for example.

In the fanciful settings of the earlier medical programs, nine out of ten have happy endings.

And what is wrong with a happy ending?

David A. Smith, M.D.
Medical Editor

correspondence

'Tell it as it is'

To the editor:

Anent your editorial in the October PM regarding the problem of chiropractic, I would like to draw attention to the September and October issues of *Consumers' Report* which contain a two part series on the subject. These articles written by consumers for consumers tell it as it is and lay out some amazing revelations that any user of the process should know about. I have ordered reprints of these articles to keep on my waiting room tables and to give to any particular patients who might profit from reading them.

George R. Hart, M.D.
New Castle

"Sorry, no free medical advice, my insurance company has just stopped selling malpractice coverage!"

practice management

Personnel management rules 'critical' factor

LEIF C. BECK, LL.B.

VASILIOS J. KALOGREDIS, J.D.

Bala Cynwyd

This month's article continues our discussion of various important ideas for effective "people management." In summary of all these ideas, we cannot stress enough how creation of a good lay staff will be essential to a practice's success.

Staff meetings

All personnel should attend an office meeting at least once a month on a regular and continuing schedule. It might be every other Wednesday at 12:30, just for example, or whatever time all the aides and the doctor or doctors can attend. Each doctor should consider it necessary for his attendance at almost all of these meetings, for the sessions enable both sides to openly discuss their respective needs and problems.

The regular and continuous staff meetings tend to build up office morale ("team spirit") since all persons involved can share in dealing with office concerns. What is more, the staff will usually be best able to suggest improvements in office routines, usually the persons most closely involved with them. Office surveys by outside management consultants, by the way, usually obtain most of their recommendations from the aides.

Some of the meetings should have specific agendas prepared either by the doctor or by the office manager. Other meetings need have no agenda at all. At some sessions, the doctor should describe selected aspects of medicine as *education* for the aides—an excellent way to improve both employee effectiveness and interest.

The common experience among physicians is to hold only an occasional meeting when considered necessary, usually when there are complaints or pressing problems to be worked out. Such staff meetings tend to be "crisis oriented" at which good, open discussion is hard to develop. In the alternative, the uniqueness of only an occasional meeting causes a reluctance among the aides to speak out. Only after a few meetings have occurred on a *regular* and *continuing* basis are the aides likely to overcome any natural reticence and begin to contribute to the communication process.

Periodic review and evaluation

Another essential to good personnel management is the regular review and evaluation of each employee's work. In most cases, this can and should be accomplished annually on a specific schedule coordinated with salary raises.

The evaluation should involve a private meeting between the doctor (or, in a larger office, the office manager) and the aide, in which that person's work performance can be discussed openly and constructively. Good aspects should in fact be stated and praised, for this feeds strongly on the ego aspects of an employee's performance—often as important as compensation. Areas in which the aide needs improvement should similarly be discussed, with inquiries including whether the office (or the doctor himself) might not be at fault.

Such evaluation sessions obviously require some advance thought by the doctor. If there are several doctors in the practice, input should come from all of them, as well as from the office manager or senior aide, before meeting with the employee. While the doctor's time involvements might discourage him from these efforts, common experience shows that the sessions are most important in maintaining office morale and improving individual performances.

One problem commonly feared by physicians is the need to fire an aide. This should arise less frequently if candid evaluation sessions are held. A marginal (or submarginal) employee can thus be told of the office's present dissatisfaction with her performance, perhaps be encouraged to seek another job or else to improve her work. At any rate, the evaluation session should make the actual act of firing an employee less intolerable, since some groundwork should have been laid.

Some doctors complain of constant pressures to raise their aides' salaries. Others report virtually no salary increases for several years, in which cases the aides have expressed considerable unrest. In either case, adoption of a single date each year when all salaries will be reviewed and adjusted creates by far the best employee climate. The *annual salary review* prevents the employer from being "whipsawed" by successive aides' pressures for pay raises, while on the other hand it assures the staff of fair consideration of all wages once a year.

There are several approaches to "annual salary review." In one approach, a specific day (or week) of the year would

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.

be set as "salary review day" (or week), for pay changes to begin on a specific date thereafter. The date might be each January 1, each July 1, or whatever fits the particular office, but all aides should know that it is the only time when salaries are changed. The other common approach is to evaluate each individual on the *anniversary date* of her starting employment with the office. The process would be the same, but under this approach the reviews would arise throughout the year and salary changes would thus be staggered.

Under either method each individual need be evaluated only once a year but she will be assured of consideration annually. The employees would understand that their salaries are directly related to their work quality, while the doctor would be freed from pressures for salary changes at other times.

A newly hired aide should be subjected to more current evaluation. One very desirable approach is to term new employees as "probationary" for the first three months, at the end of which an individual evaluation meeting will be held with her. If her work is satisfactory, she would cease to be probationary and possibly even be given a raise in pay at that time. If she has not performed well, her employment might be terminated on the conclusion that it will be better to recruit anew than to struggle on with a marginal employee; or she can be continued as probationary for an additional period after discussing the problems with her.

Compensation and benefits

Salary levels—Although of utmost importance, it is virtually impossible for any outside advisor to indicate what salary level is appropriate for each job in a medical office. Satisfactory weekly pay differs from region to region, from center city to suburbs, and even from office to office. It must simply vary with the circumstances of each job and even of the person considering it.

Smaller offices are able to respond to these variations best, for they can recruit and pay each aide in comparative (but far from total) isolation from what the other aides are already receiving. Large offices and clinics will more often find themselves locked into pay scales for each class of job within the office.

One overriding point of importance, however, is that an excellent office staff is worth the highest level of pay. Lower salary levels are likely to attract less valuable assistance, an obvious example of the old adage that "you get what you pay for." The underpaid aide is likely to have the least incentive in performing her job well and is most likely to shop around for a better paying job opportunity. How much better it might be to pay a good aide well to solidify an office's employee base than to endure less than optimal performance, poor morale, and high employee turnover.

Pay raises and bonuses—As a function of employee evaluation and to keep salary reviews systematic (discussed previously), there should be a flat policy against any pay raises except upon the specified "salary review dates." Even if an aide has performed unusually well or assumed a higher level of responsibility, she should only be promised consideration when the date comes. Such a policy will normally be acceptable if the doctor in fact respects the obligation to act on the specified date and if he is fair in raising pay as deserved at that time.

In a similar vein, bonuses should be discouraged—if not absolutely prohibited. Paying one person, or the entire staff, a bonus for some special job performance merely opens up an expectation of bonuses every time performance is good. Thus, the bonuses tend to destroy the concept of periodic evaluation of *total* performance, with adjustments (up or down) based upon the whole picture.

Special gratuitous bonuses, such as Christmas bonuses, should also be avoided. The gift of a sum of money at Christmas will promptly become a pattern, so that it no longer represents a gift out of holiday spirit. A very small gift or gift certificate to each aide would seem better to convey the season's wishes than would a virtually required and sometimes substantial cash bonus. And the aides will measure their jobs by *total* pay, not by the presence or absence of a Christmas stipend.

Overtime pay—An office tends to function in the most open and professional manner if each aide merely feels

MEDICAL OFFICE SYSTEMS AND MANAGEMENT

First of a series designed for office managers, receptionists, bookkeepers, secretaries, and other medical office aides
Presented by Leif C. Beck, LL.B., and Vasilios J. Kalogredis, J.D.
Management Consulting for Professionals, Bala Cynwyd
903 the Barkley Building
Bala Cynwyd, PA
Telephone 215-667-3655
DATE: February 18, 1976, from 9:00 a.m. to 5:00 p.m.
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responsible to contribute without punching a time clock. Of course, that attitude will be destroyed if the employer-doctor fails to recognize the aides' contributions in total pay and in his good faith. On these bases, it is often felt that careful time records and overtime pay policies should be avoided.

Unfortunately, however, various laws are making it increasingly difficult to avoid strict time recordings. The Federal Wage and Hour Law requires overtime pay for work over 40 hours per week in any office having a gross income over $250,000—a figure not unusual in most two or three-man practices. Some state laws may be still more restrictive. The new Federal pension laws require inclusion of any employee in retirement plans if she has 1,000 hours of work in a year, necessitating more timekeeping.

As a result, while attempting to disregard overtime pay as less than "professional," offices may find themselves saddled with the obligation. Time and a half for work over 40 hours would seem most appropriate, with hopes that an office's general climate permits all employees to account for their time with some flexibility.

Part time employees—Medical offices are particularly appealing employers of part time help. Former nurses whose children are in school and people hoping to "moonlight" during evening office hours are just two common examples.

A doctor should be extremely receptive to the part time job market, for several half-day aides may uniquely fit his office needs. These people may also present the special advantage of being able to fill into jobs whenever an aide is absent. Despite these advantages, however, the doctor should be careful to have at least one or two full time aides to provide some basic continuity in the office and with the patients.

Part time pay levels are even more unpredictable than full time salaries. They will depend not only upon the general job market but also upon each specific person's need or desire to work at all. The pay will in most instances be for each hour worked, with no fringe benefits, vacations or sick leave, but if a regular work schedule develops it could instead be at a weekly rate with proportionate benefits.

Fringe benefits—The traditional doctor's attitude that his aides would rather have extra cash income than fringe benefits is probably still true in most cases. It is, however, bucking a trend towards a total benefit package that must be recognized. Competition for competent aides is increasing to the point that doctors in some areas find it difficult to hire adequate help, especially where other potential employers may be offering generous fringe benefit packages along with comparable salaries. Large corporations, governmental agencies and, increasingly, hospitals offer such packages as a matter of course.

Similarly, the trend toward incorporating of medical practices has hastened the offering of fringes. The tax law simply requires some degree of comparability in benefits as between the owner-doctors and the lesser paid aides. This in turn puts more competitive pressure on unincorporated practices.

Aside from these competitive recruiting aspects, benefit programs may be unique contributions to the aides' general well-being. Thus, fringe benefits can be most helpful in developing and maintaining an effective, loyal staff. Intelligent efforts to consider the needs of most office staff and make a benefit program as helpful as possible will in some cases foster office morale even better than cash.

The common benefits to be considered include the following: (a) hospitalization insurance (Blue Cross/Blue Shield, or its equivalent) and possibly major medical insurance; (b) disability income insurance; (c) malpractice insurance; (d) life insurance; (e) retirement plan or plans.

Since one of the purposes of a fringe benefit is to foster employee incentive and morale, it is shocking how often doctors overlook properly describing the programs to their aides. This is particularly true of incorporated physicians who apparently provided the benefit only "because our lawyers told us we had to do so." If the benefit is offered at all, for whatever the underlying reason, a physician should assure that it is known to and appreciated by the employees to the fullest extent possible. This is a matter of communication and promotion, vital parts of good employer-employee relations which commercial organizations take very seriously but which medical practices tend to ignore.

Office personnel policies

Even though the average medical office may pride itself on its friendly, relatively informal working atmosphere—befitting its "professional" character—there should be a set of basic rules for all employees to know and respect. Policies as to working conditions, vacation and sick leave rights, salary adjustments and fringe benefit entitlement are, for example, effective only if they are accurately understood and appreciated by the people involved. Thus, they should be reduced to writing and given to each aide promptly upon her first day of work.

Doctors sometimes react against a set of written rules on the basis that they make their working relationship too "impersonal." Others claim they prefer to treat their few employees as "flexibly" as possible, and they believe written policies (if any exist) would limit their freedom to treat each employee and each situation independently.

The fact remains, however, that a doctor has more to lose than he can ever gain from the lack of written policies. One of the worst personnel problems is lack of communication, with an employee's resulting uncertainty as to *exactly* what her rights and obligations are. It is far better that an aide know she will not be paid for more than a specific number of days' sick leave than for her to be uncertain—and far easier emotionally for the doctor if she should actually become ill. Similarly, as discussed before, it is better that an employee know when her pay will be reviewed than for her to either (1) raise the subject at the wrong time and hence be turned down, or (2) quietly develop a pique that she has not been given a supposedly deserved increase.

The use of written personnel policies has still another advantage. If, as suggested previously, the practice provides various fringe benefits they should certainly be made known to the recipients. The benefits are advan-

tageous to the employees who should be caused to appreciate their value to the fullest extent possible. Putting them into writing and handing a copy of such a manual to each aide will usually be the best way to "sell" the staff the program.

Furthermore, putting office policies in writing need not affect the personal relationship and informality that may exist in an office. The policy manual can be given each present and future employee in a friendly manner as the doctor's effort to keep his aides well informed. The office's personality and productivity will depend on its people, not on the writing.

Some offices, particularly larger practices, seem to suffer from overwritten office policy manuals. These manuals become virtual books on every phase of the office, from use of the duplicating machine, to how to answer and transfer telephone calls, to procedures for laying out medical reports, *ad nauseum*. While all these matters deserve attention, their inclusion in one book tends to dilute the staff's understanding of basic employee rules and benefits. A short, concise statement of the policy matters can be prepared fairly easily with the result that they will not become lost in a morass of other detail. Hence, they will be most likely understood and accepted by the aides, minimizing potential office friction.

Even a solo physician with only one present aide should draft and deliver his "Office Personnel Policy" manual. It may be only a one or two page memo and it should not consume much time.

Bonding of Aides

No matter how much a practice may trust and respect its aides, it should take out a "fidelity bond" insuring them and the practice against loss by theft or otherwise. The cost is minor, yet the likelihood of insurance repayment in case of loss is some comfort also to both the employer and the employee. Having the bond may serve as a deterrent to a dishonest aide, whether present or future, since it is usually well known that the insurer will take harsher action against a suspected embezzler than will the doctor himself. Just the question to a job applicant, "Do you object to being bonded?" will sometimes flush out a person with previous history of theft.

Taking out a fidelity bond is in no way an indictment of an office's present aides. They should be told that it is a routine step for medical offices, which it is, and they should in fact welcome the protection.

Fidelity bonds are quite inexpensive and are offered in several different forms. The cheapest would be a bond covering a specifically named individual, which might be satisfactory if only one person handles all financial dealings including collection of cash during office visits. A "position bond" would normally be more appropriate, covering each employee who performs certain tasks—perhaps bookkeeping and reception—while a "blanket bond" would be the most extensive form covering the entire staff. The proper type bond and the amount of coverage to be purchased will vary from office to office and should be discussed with a practice's liability insurance broker.

Conclusion

A good staff can make a practice far more effective. It can cause patients to be cared for better, and it can cause more of them to be seen effectively, and certainly it can make the practice more financially successful! Conversely, a poor staff or a disgruntled group of employees can negatively affect the office's medical performance and its profitability.

In light of these truisms about personnel's importance, we submit that any privately practicing doctor should take the time to develop and follow sound rules for managing his staff. His failure to take that time will almost certainly cost him dearly in time, money, and grief.

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Physicians' Responsibility In Long-Term Care Facilities

The Pennsylvania Department of Health has adopted long-term care regulations covering skilled nursing facilities and intermediate care facilities. The regulations cover many facets of operation from ownership and management through buildings and grounds, mechanical and electrical equipment, physical plant, housekeeping and maintenance, fire protection, safety, and program standards.

Excerpted below are those portions that are applicable to physicians. These regulations differ in requirements from those physicians normally perceive in a general hospital. Between skilled and intermediate facilities there are various standards with which the attending physician must comply.

The state regulations require, after December 1, 1975, that these facilities have a medical director. Federal regulations also contain this requirement. Starting December 2, 1975, the government will withhold medicare and medicaid reimbursements from any nursing home without a medical director. Only those facilities which have no medicare or medicaid patients or those that can claim they cannot meet the requirement because of a physician shortage in the area can escape this rule.

CHAPTER 211.
PROGRAM STANDARDS
FOR
SKILLED NURSING AND
INTERMEDIATE CARE FACILITIES
PROGRAM STANDARDS
APPLICABLE TO SKILLED
NURSING AND INTERMEDIATE
CARE FACILITIES

§ 211.1. Infection Control Committee.

(a) The facility shall establish an Infection Control Committee composed of members of the medical and nursing staffs, administration, and dietetic, pharmacy, housekeeping, maintenance, and other services charged with responsibility for overall infection control.

(b) The Infection Control Committee shall establish written policies and procedures for investigating, controlling, and preventing infections in the facility.

(c) The written policies and procedures in aseptic and isolation techniques shall be followed by all personnel. In the event that the facility does not have the capability of caring for a patient with an infectious disease, the written policies must include provisions for handling isolation cases until arrangements can be made to have the patient transferred to a facility capable of caring for the patients and the needs related to the specific organism.

(d) The Infection Control Committee shall monitor staff performance to ensure that the policies and procedures are executed.

(e) Procedures are reviewed and revised for effectiveness and improvement at least annually or more frequently as necessary.

(f) Minutes shall be maintained for all committee meetings.

§ 211.2. Physician services.

(a) Patients in need of skilled nursing or rehabilitative care are admitted to the facility upon the recommendation of a physician.

(b) They shall remain under the care of a physician.

§ 211.3. Medical findings and physicians' orders at time of admission.

(a) There shall be made available to the facility, prior to or at the time of admission, or within 48 hours thereafter, patient information which includes current medical findings, diagnoses, rehabilitation potential, a summary of the course of prior treatment, and orders from a physician for immediate care of the patient.

(b) The admission requirements shall include a report of a physical examination, chest x-ray and/or intermediate strength tuberculin skin test, complete blood count, and a urinalysis. These must be done within 48 hours of admission unless such examinations were performed within five days prior to admission.

(c) Annually thereafter, there shall be a physical examination, complete blood count, and urinalysis done for each patient. The results of these tests must be available on each patient chart.

§ 211.4. Patient supervision by physician.

(a) The facility shall have a written requirement that the health care of every patient must be under the supervision of a physician who, based on a medical evaluation of the patient's immediate and long-term needs, prescribes a planned regimen of total patient care.

(b) A progress note shall be written and/or typed and signed by the physician at the time of each visit.

(c) All physician's orders shall be signed by the physician.

§ 211.5. Availability of physicians for emergency patient care.

The facility has written procedures available at each nurses station that provide for having a physician available to furnish necessary medical care in case of emergency.

§ 211.6. Procedure in event of death.

(a) A body shall not be removed from the facility until death has been determined by a physician who is legally responsible for pronouncement of death.

(b) Death certificates shall be completed and signed by the physician at the time of death. The death certificate must be completed in accordance with § 502 of the Vital Statistics Law. (Clarification of this requirement has been sent to all facilities by the State Society's Council on Education and Science and will appear in the January issue of PENNSYLVANIA MEDICINE.)

(c) Written post-mortem procedures shall be available.

§ 211.9. Physician documentation.

Only physicians shall enter or authenticate in medical records any opinions that require medical judgment (in accordance with medical staff by-laws, rules and regulations, if applicable). Each physician signs his entries into the medical record.

§ 213.12. Conformance with physicians' drug orders.

(a) Drugs shall be administered in accordance with written orders of the attending physician.

(b) Drugs not specifically limited as to time or number of doses when ordered shall be controlled by automatic stop-orders or other methods in accordance with written policies.

(c) Physicians' verbal orders for drugs shall be given only to a licensed nurse, pharmacist, or physician and immediately recorded and signed by the person receiving the order. (Oral orders for Schedule II drugs are permitted only in the case of a bona fide emergency situation). Such orders shall be counter signed by the attending physician within 48 hours.

(d) The attending physician shall be notified of an automatic stop-order prior to the last dose so that he may decide if the prescription is to be renewed.

§ 213.14. Specialized rehabilitative services.

(a) In addition to restorative nursing services, the skilled nursing facility shall provide, or arrange for, under written agreement, specialized restorative services by qualified personnel (i.e., physical therapy, speech pathology and audiology, and occupational therapy, etc.) as needed by patients to improve and maintain functioning.

(b) These services shall be provided upon the written order of the patient's attending physician.

(c) Safe and adequate space and equipment shall be available commensurate with the services offered.

(d) If the facility does not offer such services directly, it shall not admit nor retain patients in need of this care unless provision is made for such services under arrangements with qualified outside resources under which the facility assumes professional and financial responsibilities for the services rendered.

(e) Rehabilitative services shall be provided under a written plan of care initiated by the attending physician and developed in consultation with appropriate therapist(s) and the nursing service.

(f) A report of the patient's progress shall be communicated to the attending physician within two weeks of the initiation of specialized rehabilitative services.

(g) The patient's progress shall thereafter be reviewed regularly, and the plan of restorative care shall be reevaluated as necessary, but at least every 30 days, by the physician and the therapist(s).

(h) The physician's orders, the plan of restorative care, services rendered, evaluations of progress, and other pertinent information shall be recorded in the patient's medical record, and shall be dated and signed by the physician ordering the service and the person who provided the service.

§ 213.28 Medical director.

(a) There shall be a Medical Director appointed no later than December 1, 1975. The following articles are a requirement when a Medical Director is appointed.

(b) The physician shall be licensed in Pennsylvania to practice medicine or osteopathy.

(c) The Medical Director may serve on a full or part time basis depending on the needs of the patients and the facility.

(d) There shall be a written agreement between the physician and the facility.

(e) If the facility has an organized medical staff, the Medical Director shall be designated by the medical staff with approval of the governing body.

(f) The Medical Director may be designated for a single facility or multiple

facilities through arrangements with a group of physicians, the local medical society, a hospital medical staff, or through another similar arrangement.

(g) The Medical Director shall be responsible for the overall coordination of the medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to patients and to maintain surveillance of the health status of employees.

(h) Incidents and accidents that occur on the premises shall be reviewed by the Medical Director to identify hazards to health and safety. The administrator shall be given appropriate information to help insure a safe and sanitary environment for patients and personnel.

(i) The Medical Director shall be responsible for the execution of patient care policies.

(j) The requirement for a Medical Director may be waived for an appropriate period of time depending on the following:

(1) The facility is located in an area where the supply of physicians is not sufficient to permit compliance with this requirement without seriously reducing the availability of physician services within the area.

(2) The facility has made continuous efforts in good faith to recruit a Medical Director, but has not been able to hire a physician due to the unavailability of physicians.

(k) Each patient shall be seen by the physician at least every 30 days or more often as needed.

(l) Every patient's total program of care (including medications and treatments) shall be reviewed and revised in writing by the attending physician at least once every 30 days or more often as necessary.

§ 213.29 Coordination of medical care.

(a) Medical direction and coordination of medical care shall be provided by the Medical Director. Coordination of medical care includes liaison with attending physicians to ensure their writing orders promptly upon admission of a patient, and periodic evaluation of the adequacy and appropriateness of health professional and supportive staff and services.

(b) The Medical Director shall be responsible for the development of written bylaws, rules and regulations which are approved by the governing body and include delineation of the responsibilities of attending physicians.

§ 215.9 Physician visits.

(a) Each patient's total program of care (including medications and treatments) shall be reviewed and revised by the attending physician at least once every 60 days or more often as necessary.

(b) Every patient shall be seen by the physician at least every 60 days or more often as needed.

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Indications: GLYCOTUSS (guaifenesin) is of value in the treatment of coughs, particularly the unproductive cough, due to the common cold

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Contraindications: Contraindicated in patients who have a history of sensitivity to guaiacol.

Side Effects: No serious side effects have been reported of guaifenesin Occasional gastric disturbance and nausea have been encountered

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See Brief Summary

*See dosage and administration section of Brief Summary

Whenever an APC/narcotic is indicated.

ach yellow, scored tablet contains 4.50 mg. oxycodone HCl (Warning: May e habit forming), 0.38 mg. oxycodone terephthalate (Warning: May be abit forming), 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

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CONTRAINDICATIONS: Hypersensitivity to oxycodone, aspirin, phenacetin or caffeine.

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Usage in children: PERCODAN should not be administered to childre".

Salicylates should be used with caution in the presence of peptic ulcer or oagulation abnormalities.

PRECAUTIONS: *Head injury and increased intracranial pressure:* The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

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Phenacetin has been reported to damage the kidneys when taken in excessive amounts for a long time.

ADVERSE REACTIONS: The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. Some of these adverse reactions may be alleviated if the patient lies down.

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Treatment: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and the institution of assisted or controlled ventilation. The narcotic antagonists naloxone, nalorphine or levallorphan are specific antidotes against respiratory depression which may result from overdosage or unusual sensitivity to narcotics, including oxycodone. Therefore, an appropriate dose of one of these antagonists should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation. Since the duration of action of oxycodone may exceed that of the antagonist, the patient should be kept under continued surveillance and repeated doses of the antagonist should be administered as needed to maintain adequate respiration.

An antagonist should not be administered in the absence of clinically significant respiratory or cardiovascular depression.

Oxygen, intravenous fluids, vasopressors and other supportive measures should be employed as indicated.

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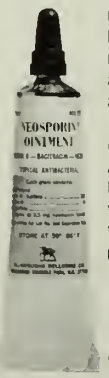
Complete literature available on request from Professional Services Dept. PML.



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WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

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Ⓒ Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

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cardiovascular brief

PENICILLIN: MULTIPLE APPLICATIONS IN RHEUMATIC PATIENTS

This is the second of two articles prepared for the American Heart Association, Pennsylvania Affiliate, by Sidney Friedman, M.D., chairman of the Affiliate's Committee on Cardiovascular Disease in the Young, and C. Robert E. Wells, M.D., committee cochairman and Affiliate vice president.

Penicillin is a very valuable antibiotic in the management of patients with streptococcal infection, rheumatic fever, and rheumatic heart disease. There are a number of distinct indications for its use, each requiring a specific preparation, dosage level, and duration of administration. An understanding of the rationale of its use in each clinical situation is essential to the proper application.

Primary Prevention of Rheumatic Fever

In 1951 it was demonstrated at the Streptococcal Disease Laboratory at the Warren Air Force Base[1] that rheumatic sequelae can be prevented following acute streptococcal infection by the prompt and vigorous treatment of streptococcal infection with intramuscular penicillin. In comparable large groups of service personnel with acute streptococcal infection, the addition of a ten-day course of intramuscular penicillin virtually eliminated rheumatic fever as a sequel to streptococcal infection. In a second control group of patients treated symptomatically without penicillin, the usual three percent incidence rate of rheumatic fever as a complication of streptococcal infection occurred. Subsequent studies have confirmed this observation and demonstrated the effectiveness of other forms of penicillin administration for this purpose, including oral penicillin-V potassium. Treatment should be started as soon as possible, but a delay of up to seven or nine days may still prevent the onset of rheumatic fever.

Penicillin is the drug of choice for primary prevention of rheumatic fever and should be continued for a period of ten days. Effectiveness is based upon the bacteriocidal qualities of penicillin against beta-hemolytic streptococci and is dependent upon the total eradication of streptococci from the throat. Penicillin may be administered by either the intramuscular or oral routes. A single intramuscular injection of the long acting respository benzathine penicillin is adequate. For adults, one intramuscular injection of 900,000 to 1,200,000 units is recommended. Using the oral route, a dose of 200,000 or 250,000 units of oral penicillin-V four times a day for a full ten days is recommended. Therapy must not be discontinued despite the prompt, favorable disappearance of fever and other symptoms and signs of infection.

Occasionally, the failure of such treatment to prevent rheumatic sequelae has been reported. In most instances, failure of the antistreptococcal treatment to completely eradicate the organism has been responsible. The following principles must be applied if this method of prevention is to be successful: (1) the streptococcus itself must be eradicated; clinical cure alone is inadequate. (2) To achieve such eradication, the bacteriocidal property of penicillin should be used. Sulfonamides are ineffective for this purpose. The tetracycline compounds are effective, but not to the same extent as penicillin. (3) Treatment must provide penicillin for at least ten days in adequate amounts to ensure complete eradication of the organism.

The Use of Penicillin in Patients with Acute Rheumatic Fever

Among pediatric patients hospitalized for acute rheumatic fever, only 60 percent will yield a positive throat culture for beta-hemolytic streptococci. In contrast, almost 95 percent of such children will show serologic evidence of antecedent streptococcal infection when a battery of tests are performed to detect a variety of anti-streptococcal antibodies. From this data as well as from epidemiologic information, it is widely assumed that every rheumatic episode, initial and recurrent, is preceded by a beta-hemolytic streptococcal infection. It would thus seem wise to treat every patient with acute rheumatic fever with a ten day course of penicillin without delay, that is, before the results of the throat culture are available. In this way, the mysterious relationship between the streptococcal organisms and the rheumatic inflammatory process will be interrupted. A ten day course of penicillin similar to that used in primary prevention should be given. Thereafter the same individuals must be maintained on oral or intramuscular doses of penicillin equivalent to those used in the secondary prevention of rheumatic fever. This is especially important for children exposed to the bacteriologic flora of pediatric hospital units.

1. Wannamaker, L.W.; Rammelkamp, C.H., Jr.; Denny F.W.; Brink, W.R.; Houser, H.B.; and Hohn, E.O. Prophylaxis of acute rheumatic fever by treatment of the preceeding streptococcal infection with various amounts of depot penicillin. Am. J. Med. 10:673, 1951.

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continuing education

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Gregory Klimock, M.D., Pathology, Grove City Hosp., Grove City 16127.
Ramnath Rau, M.D., Internal Medicine, Medical Arts Bldg., Sharon 16146.
Shen-Chi Wang, M.D., Pathology, Sharon Gen. Hosp., Sharon 16146.

MONTGOMERY COUNTY:
Henry C. Schneider, Jr., M.D., Urology, 1322 Highland Ave., Abington 19001.

MONTOUR COUNTY:
Hansel Debartolo, Jr., M.D., Otolaryngology, Geisinger Med. Ctr., Danville 17821.
Charles T. Grad, M.D., Internal Medicine, Geisinger Med. Ctr., Danville 17821.
Radu I. Pacurariu, M.D., Ophthalmology, Geisinger Med. Ctr., Danville 17821.
P. Ronald Zug, M.D., Internal Medicine, 27 Vine St., Danville 17821.

NORTHAMPTON COUNTY:
Parimak K. Ghatak, M.D., Internal Medicine, 101 S. Schanck Ave., Pen Argyl 18072.
Bruce M. Kaufman, M.D., Obstetrics and Gynecology, 800 Ostrum St., Bethlehem 18015.
Pei S. Lin, M.D., Otolaryngology, Easton Hospital, Easton 18042.
George O. Maish, Jr., M.D., General Surgery, 35 E. Elizabeth Ave., Bethlehem 18018.

NORTHUMBERLAND COUNTY:
John P. Pagana, M.D., Family Practice, 316 N. 12th St., Sunbury 17801.
Longway Tsai, M.D., Pediatrics, 1138 Chemung St., Shamokin 17872.
Tei-Chen Wang, M.D., Family Practice, 917 Center St., Shamokin 17872.

PHILADELPHIA COUNTY:
Juan Arentsen, M.D., Ophthalmology, 1601 Spring Garden St., Philadelphia 19130.
Allen H. Bar, M.D., General Surgery, 330 S. 9th St., Philadelphia 19107.
Edward C. Bradley, M.D., Internal Medicine, Thomas Jefferson University, Philadelphia 19107.
Jerome I. Brody, M.D., Internal Medicine, 3300 Henry Ave., Philadelphia 19129.
Earl H. Brown, M.D., Family Practice, 314 Rear S. Olive St., Media 19063.
Cecilia B. Calderon, M.D., Pathology, 230 N. Broad St., Philadelphia 19102.
Norman Castel, M.D., Family Practice, 2500 Belmont Ave., Philadelphia 19131.
Dong S. Cha, M.D., Plastic Surgery, 666 E. Penn St., #202, Philadelphia 19144.
Mao-Hsiung Chen, M.D., Anesthesiology, Northeastern Hosp., Philadelphia 19134.
Sook P. Choh, M.D., Anesthesiology, 3300 Henry Ave., Philadelphia 19129.
Whan S. Chung, M.D., Obstetrics and Gynecology, Front St. and Lehigh Ave., Philadelphia 19125.
Paul A. Cohen, M.D., Internal Medicine, 2238 Mt. Vernon St., Philadelphia 19130.
James J. Corbett, M.D., Neurology, 130 S. 9th St., Philadelphia 19107.
Gary S. Coren, M.D., Radiology, 380 Rennard St., Philadelphia 19116.
John R. Durocher, M.D., Internal Medicine, Pennsylvania Hosp., Philadelphia 19107.
Dionisio Felix, M.D., Obstetrics and Gynecology, 441 Tomlinson Rd., #D-7, Philadelphia 19116.
Phillip Glass, M.D., Obstetrics and Gynecology, 1919 Chestnut St., Philadelphia 19103.
Panchadcharam Gnaneswaran, M.D., Obstetrics and Gynecology, 230 N. Broad St., Philadelphia 19102.
David M. Goodner, M.D., Obstetrics and Gynecology, 7205 Charlton St., Philadelphia 19119.
Dov Gorshein, M.D., Internal Medicine, 1900 S. Broad St., Philadelphia 19145.
Earl F. Greenwald, M.D., Obstetrics and Gynecology, 3401 N. Broad St., Philadelphia 19140.
Fawzi P. Habboushe, M.D., General Surgery, 1229 Waverly Rd., Gladwyne 19035.
Martin F. Hayes, Jr., M.D., General Surgery, 230 N. Broad St., Philadelphia 19102.
Sanford L. Herold, M.D., Internal Medicine, 220 E. Mermaid Ln., #142, Philadelphia 19118.
Norman B. Hollingsworth, M.D., Anesthesiology, AEMC Anesthesiology Associates, Philadelphia 19141.
Robert G. Kettrick, M.D., Anesthesiology, One Children's Ctr., Philadelphia 19104.
Gary H. Kramer, M.D., Psychiatry, 2375 Woodward Ave., Philadelphia 19115.
Ronald Liebman, M.D., Psychiatry, 624 Greythorne Rd., Wynnewood 19096.
Karin F. Mack, M.D., Psychiatry, 518 S. 21st St., Philadelphia 19146.
Thomas M. McGuigan, M.D., Family Practice, 5203 Burton St., Philadelphia 19124.
Joel Morganroth, M.D., Internal Medicine, 2600 Conshohocken Ave., Philadelphia 19131.
Alfredo L. Pauca, M.D., Anesthesiology, 726 Darby Paoli Rd., Newtown Square 19073.
Dowray Ramesh, M.D., Family Practice, 2601 Holme Ave., Philadelphia 19152.

POTTER COUNTY:
Celso L. Backes, M.D., Obstetrics and Gynecology, Charles Cole Mem. Hosp., Coudersport 16915.

SOMERSET COUNTY:
Jerry L. Gray, M.D., Internal Medicine, Windber Med., Bldg., Windber 15963.

VENANGO COUNTY:
Alberto J. Liberman, M.D., Obstetrics and Gynecology, 7 Vo-Tech Dr., 1-B, Oil City 16323.
Leonard L. Peters, M.D., General Surgery, 320 16th St., Franklin 16323.

WASHINGTON COUNTY:
Jesus S. Evangelista, M.D., Family Practice, 115 Mohawk St., Cohoes, NY 12047.
Allen J. Merzi, M.D., General Surgery, 150 W. Beau St., Washington 15301.

WAYNE-PIKE COUNTY:
John M. Atkinson, M.D., Obstetrics and Gynecology, Box 93, Beach Lake, Wayne 18405.

WYOMING COUNTY:
Ernest R. Gerfin, M.D., Pathology, Tyler Mem. Hosp., Tunkhannock 18657.
John F. McIntyre, M.D., Family Practice, R.D.#1, Tunkhannock 18657.

classifieds

PHYSICIANS WANTED

Excellent Group Practice Opportunities for primary care physicians, medical, surgical specialists, pediatricians, psychiatrists, dermatologists in beautiful university community with hospital privileges available. Contact Indiana Medical Center, Heatherbrae Square, Indiana, PA 15701; telephone (412) 465-2056.

Emergency Physicians—A multi-hospital group of emergency physicians seeks members for full-time positions at major hospital emergency departments in Philadelphia and other areas of Pennsylvania. In addition to full-time emergency physicians, a physician director is sought for each emergency department. The group encourages professional and administrative autonomy in its member physicians. Financial arrangements are fee-for-service with minimum guarantee. Emergency-oriented educational programs for physicians are maintained by the group at no charge to its members. Compensation ranges from $40,000 to $60,000 per year for 48 hours per week. Write: Department 650, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, Pa. 17043.

Psychiatrists, Physicians with Psychiatric Experience—Mental hospital in metropolitan area. Easy access to New York, Philadelphia, and close to Pocono resort area. Good salary with excellent fringe and retirement benefits. Pennsylvania license required. Contact: Henry Buxbaum, M.D., Superintendent, Clarks Summit State Hospital, Clarks Summit, PA 18411. Telephone: (717) 586-2011.

Anesthesiologist—Board Certified. To head department of seven C.R.N.A.s with a moderate surgical volume. 242 bed hospital in economically strong, progressive community of 60,000 in south central Pennsylvania, 60 miles east of Pittsburgh. Remuneration open. Contact T. R. Baranik, Administrator, Mercy Hospital of Johnstown, 1020 Franklin St., Johnstown, PA 15905; (814) 536-4461.

Pediatrician—Needed in College town with drawing population of 25,000 located at intersection of I-79 and I-80. Growing area, clean air, good schools in Western Pa. Substantial Guarantee. Contact: Mr. J. A. Colaizzi, Adminstrator, Grove City Hospital, Grove City, PA 16127; telephone (412) 458-7132.

Board Eligible/Board Certified Anesthesiologist—Regular part time. Take some calls from home; no OB. Write Department 690, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

Camp Physician—July-August for 2, 4 or 8 week period. NE Pennsylvania, family accommodations, private lake, tennis, et al. 2 RNs. Write Camp Wayne, 633 Barnard Ave., Woodmere, NY 11598; (516) 295-5544.

Psychiatric Assistant Director—Private 11 team facility. Central location, NY, Philadelphia, Poconos. 2-4 years personal analysis; 5 years private practice; Pa. license; fringe benefits; pension plan. Salary negotiable. Begin immediately. Box 3023, Wescoesville, PA 18090.

Pediatrician, Internist, Generalist—For full time staff position in Rehabilitative Facility for the multihandicapped including deaf, cerebral palsied and exceptional students. A large residential and day population involved in a wide variety of therapeutic and educational programs, including a comprehensive, multidisciplined evaluation of the multihandicapped. Immediate opening Suburban Philadelphia area. Reply Department 687, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

Radiologist—Board certified or eligible. Salaried position. 200 bed hospital embarking on a multi-million dollar building program. University community 60 miles NE of Pittsburgh. Associate position with opportunity to assist in planning new department of radiology. Contact Donald F. Smith, Administrator, Indiana Hospital, Indiana, PA 15701; telephone (412) 463-0261.

Surgical Department Chairperson—Immediate opening. Full time position with practice privileges in 700 bed medical school affiliated teaching center. Seeking board certified surgeon with administrative, academic, and research experience to head established four year approved surgical program. Norman N. Cohen, M.D., Chairman, Search Committee, Mercy Catholic Medical Center, Darby, PA 19023.

Emergency Care Unit Physician—Needed to complete six man full time emergency care group. Excellent specialty backup. Active teaching hospital (600 beds). Ten paid sick days per year and ten paid vacation days per year to start. Twelve hour shifts. Work five days, off five days. Excellent working facilities. Send resume and salary requirements to Department 689, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

General or Family Practitioner—Wanted to take over growing family practice. Fully equipped office provided at no expense. Close to Pittsburgh and Wheeling. Access to 3 large hospitals with family practice residents. Evening and weekend coverage available. Write P.O. Box 6020, Wheeling, WV 26003.

Emergency Room Physician—For 340 bed hospital. St. Joseph Hospital is located in Lancaster, Pa., a medium sized city in the heart of Pennsylvania Dutch Country. Lancaster is a charming community, rich in history, in close proximity to Philadelphia, Baltimore, and New York. Excellent school systems and three colleges—F & M, Elizabethtown, and Millersville State College. Extremely liberal fringe benefit package including strong retirement program, major medical to $1,000,000, long term disability, vacations, etc. (most programs begin after 1 year service). Applicants must be licensed in Pennsylvania. Salary negotiable. 42 hour week. Please direct reply to Kenneth M. Carroll, M.D., St. Joseph Hospital, 250 College Ave., Lancaster, PA 17604; phone (717) 397-2821.

Psychiatrists and Physicians—All Levels—Accredited Hospital. Affiliated with approved general hospital for all medical and surgical treatment as required. $22,351 to $29,869 and liberal fringes. Limited housing possible. Pennsylvania license required. Robert L. Gatski, M.D., Director, State Hospital, Danville, PA 17821.

House Staff Physician—280 bed accredited hospital seeks Pennsylvania licensed physician for 40 hours per week plus two nights per week. Located in the beautiful suburbs of Philadelphia. Paid malpractice insurance, pension plan, hospitalization, sick leave, vacation, disability insurance and other attractive benefits. $28,500 per year. Call or write T. A. Harrington, Administrator, Holy Redeemer Hospital, Meadowbrook, PA 19046; (215) 947-3000.

Orthopedic Surgeon—Needed in College town with drawing population of 25,000 located at intersection of I-79 and I-80. Growing area, clean air, good schools in Western Pa. Substantial Guarantee. Contact: Mr. J. A. Colaizzi, Administrator, Grove City Hospital, Grove City, PA 16127; telephone (412) 458-7132.

Internist/GP—Salary $30,000 range plus benefits. Located in Finger Lakes Region, gracious country living. Non-discrimination in employment. Malpractice insurance not necessary. Contact Chief of Staff, VA Center, Bath, NY 14810.

Anesthesiologist—Needed in College town with drawing population of 25,000 located at intersection of I-79 and I-80. Growing area, clean air, good schools in Western Pa. Substantial Guarantee. Contact: Mr. J. A. Colaizzi, Adminstrator, Grove City Hospital, Grove City, PA 16127; telephone (412) 458-7132.

Emergency Room Physician—To complete group in recently completed modern Emergency Room Suite with chopper pad. Excellent compensation includes malpractice coverage. Service area of approx. 50,000 population with excellent school system from Kindergarten through 4 area colleges. Cultural and recreational activities include hunting and fishing. Major metropolitan areas including New York, Philadelphia and Pittsburgh are within 3 to 5 hours commuting distance. Contact: A. W. Speth, Administrator, Lock Haven Hospital, Lock Haven, PA; Call Collect (717) 748-7721.

Chairman, Department of Medicine—525 Bed Community Hospital. Southwestern Pennsylvania, approved residency in internal medicine. Salary and benefits negotiable. Contact: D. I. Zubritsky, M.D., Chairman, Search Committee, McKeesport Hospital, 1500 Fifth Avenue, McKeesport, PA 15132.

Psychiatrist—Full or part time at accredited 500 bed State Mental Hospital with convenient North Boros location in suburban Pittsburgh. Excellent working conditions and state fringe benefits, salary competitive. Requires Pennsylvania license and completion of 3 year residency. Equal opportunity employer. Contact: Superintendent, Dixmont State Hospital, Sewickley, PA 15143; (412) 761-1780.

Emergency Room Physician—New 204 bed general hospital, in Western Pennsylvania 55 miles north of Pittsburgh. Full time position. Hourly rate plus liability, life, health, workmen's compensation, unemployment compensation, retirement, holidays, vacation, salary continuation for sickness or disability. Pennsylvania license required. Fishing, hunting, and other recreational opportunities on unpolluted Allegheny River. Contact F. O. Robertson, M.D. (412) 542-5404.

POSITIONS WANTED

Internist—28, American graduate, University trained, desires position in eastern Pennsylvania. ABIM eligible and available July 1976. Write Department 688, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne PA 17043.

FOR RENT

Professional Office Space—Three examination rooms; available in whole or part plus supporting facilities. 1432 E. Washington Lane, Philadelphia, PA 19138. Contact Dr. Edward Williams (215) 276-8100.

FOR SALE

Institutionally Zoned Parcel of 3 acres plus, in Warminster Township, Bucks County. Ideally situated for medical clinic, nursing or convalescent home. Contact: Glen-Mont Realty Co., 104 Keswick Ave., Glenside, PA 19038; or call (215) 886-4730.

MISCELLANEOUS

Biomedical Electronics Service—Repairs EEG, EKG, x-ray, and other electronic equipment. Will install and remove x-ray equipment. Walker Electronics, 117 Sylvan Terrace, Harrisburg, PA 17104; telephone (717) 238-1369.

obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Robert S. Baylor, Jr.**, Waynesboro; Jefferson Medical College, 1929; age 72; died September 1, 1975. He had served as secretary and president of the Franklin County Medical Society. His wife and several children survive him.

• **Saverio F. Brunetti**, Philadelphia; Hahnemann Medical College and Hospital, 1925; age 75; died January 24, 1975. Information regarding survivors is unavailable.

• **Peter J. Castelli,** Pittsburgh; University of Pittsburgh School of Medicine, 1941; age 67; died October 25, 1975. He is survived by his wife, four daughters, and one son, Peter J. Castelli, II.

• **Franklin A. Chagan,** Philadelphia; Hahnemann Medical College and Hospital, 1934; age 65; died October 24, 1975. His wife and three sons survive him.

• **Charles L. Fackler**, York; Jefferson Medical College, 1916; age 81; died October 18, 1975. He is survived by his wife, a sister, and a brother.

• **James J. Flannery**, Ashland; Jefferson Medical College, 1920; age 79; died October 4, 1975. He had practiced medicine for over 50 years. Surviving are his wife, two sons, two daughters, and a brother.

• **Erwin D. Funk,** Wyomissing; Jefferson Medical College, 1911; age 91; died October 21, 1975. He was former medical director and chief of pathology at the Reading Hospital, and a past president and treasurer of the Berks County Medical Society. He had received an honorary doctor of science degree from Albright College in 1937. Two daughters and a son survive him.

• **Robert C. Grauer,** Pittsburgh; University of Pittsburgh School of Medicine, 1927; age 73; died October 24, 1975. Until his retirement in 1973, he was director of the William H. Singer Memorial Research Institute and head of the endocrinology department at Allegheny General Hospital. He was a past president of the Allegheny County Chapter of the American Cancer Society and the Pittsburgh Academy of Medicine, a fellow of the American College of Physicians, and on the board of directors of the Health Research and Services Foundation of the United Fund (now the United Way). Other memberships included the American Association for the Advancement of Science, American Association for Cancer Research, International Academy of Pathologists, and the Society for Experimental Biology and Medicine. His wife and a son survive him.

• **Jay G. Linn, Sr.**, Pittsburgh; University of Pittsburgh School of Medicine, 1911; age 88; died July 12, 1975. He had been on the emeritus staff of Pittsburgh Eye and Ear Hospital since 1952. Professional affiliations included the Pittsburgh Ophthalmological Society, Pittsburgh Academy of Medicine, American Academy of Ophthalmology and Otolaryngology, American Association for the Advancement of Science, and the French Ophthalmological Society. He was an associate for research in ophthalmology in the American Geriatric Society. His wife, a son, Jay G. Linn, Jr., M.D., and two daughters survive him.

• **Edward H. Meizlik**, McKeesport; University of Pittsburgh School of Medicine, 1940; age 59; died September 27, 1975. He is survived by his wife.

• **Thomas H. Murphy**, Pittston; Temple University School of Medicine, 1932; age 80; died August 31, 1975. Surviving are his wife and a brother, Michael J. Murphy, M.D.

• **Hope T. M. Ritter**, Allentown; University of Pennsylvania School of Medicine, 1902; age 96; died October 15, 1975. In 1966 the Lehigh County Medical Society honored him for 64 years as a general practitioner. When he retired in 1968 he received the Allentown Exchange Club's Golden Deeds Award for his service to the community. His wife, a daughter, and a son, Hope T. M. Ritter, Jr., M.D., survive him.

• **George W. Taggart**, Hazleton; University of Pennsylvania School of Medicine, 1921; age 78; died September 28, 1975. He was honored by the Luzerne County Medical Society for 50 years of service; he was a past president of the Hazleton Branch of the Luzerne County Medical Society. Surviving are a son, G. Webster Taggart, M.D., a brother, and three sisters.

• **William B. Turner,** Carlisle; Medical College of South Carolina, 1934; age 67; died October 31, 1975. His wife, a daughter, a son, two brothers, and four sisters survive him.

• **J. McClure Tyson**, DuBois; Jefferson Medical College, 1918; age 81; died October 10, 1975. Information regarding survivors is unavailable.

• **Norman Williams,** Philadelphia; St. Mary's Hospital of London, 1941; age 57; died April 24, 1975. Information regarding survivors is unavailable.

George Rosenbaum, Philadelphia; University of Maryland Medical School, 1905; age 91; died October 20, 1975. Two sons and a sister survive him.

Joseph B. Sarner, Philadelphia; University of Pennsylvania School of Medicine, 1941; age 60; died October 1, 1975. He was chief of proctology at Pennsylvania Hospital, a professor at the Graduate School of the University of Pennsylvania, and a fellow of the College of Physicians of Philadelphia. He is survived by his wife, a son, a daughter, and a sister.

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Proceedings 126th Annual Session of the House of Delegates

Lancaster, October 6-8, 1975

(Secretary's Note: Favorable action by the House of Delegates on the recommendations of the reference committees can be assumed unless reported otherwise.)

Special Session of the House, October 6, 1975

The speaker called the Special Session of the House of Delegates to order at 1:00 p.m., Monday, October 6, 1975, in the ballroom of the Host Farm Motel, Lancaster. He announced that the first item of business is the Special Session of the House of Delegates which was first called to order on July 2, 1975, and which went into recess on July 3. The current malpractice crisis may necessitate recalling the House to Special Session on brief notice, if developments in the malpractice crisis so require. This could be expedited by maintaining the Special Session in recess.

J. Campbell Martin, M.D., Columbia County, chairman of the Committee on Credentials, reported that a quorum was present.

The speaker introduced the following resolution:

WHEREAS, Further developments in the professional liability insurance crisis may require a swift reaction from the Society's Delegates; and

WHEREAS, The swift response will be possible only by continuing the Special Session in recess; therefore be it

RESOLVED, That this House unanimously express its wish to continue the Special Session in recess.

A voice vote was called and the resolution was adopted with no dissenting votes.

The Opening Session of the House, October 6, 1975

The speaker called the opening session of the House to order at 1:20 p.m., Monday, October 6, 1975, in the ballroom of the Host Farm Motel, Lancaster. After receiving a report from the chairman of the Committee on Credentials, that a quorum was present, John B. Lovette, M.D., speaker, called upon Robert Poole, III, M.D., Chester County, past chairman of the Pennsylvania Medical Society Committee on Medicine and Religion and past member of the American Medical Association Committee on Medicine and Religion, to offer the invocation. Following Dr. Poole's invocation, the speaker asked that there be no smoking in the House of Delegates, and that anyone presenting amendments to the resolutions and motions prepare a written copy and deliver it to either the speaker or vice speaker.

Committee on Rules

William A. Shaver, M.D., Lebanon County, chairman of the Committee on Rules, presented the following written report:

"Mr. Speaker and members of the House of Delegates:

"The Reference Committee on Rules met and unanimously approved the adoption of the Standing Rules of the House of Delegates of the Pennsylvania Medical Society as published on pages 4-6 of the 1975 *Official Reports*, including the new proposed Standing Rule No. 8 dealing with the motion to vote immediately or terminate debate.

"Mr. Speaker, I recommend that the Standing Rules of the House of Delegates, including the proposed Standing Rule No. 8 be adopted as presented."

Necrology Report

The House stood in tribute following the Necrology Report presented by Cyrus B. Slease, M.D., chairman of the Board of Trustees:

"At this time it is customary to ask you to give a moment's thought to our members who may have been with us here a year ago, but, in the past months, have responded to their last roll call. Their names have been memorialized in county medical society bulletins and in PENNSYLVANIA MEDICINE, the journal of the Pennsylvania Medical Society.

"Among those who passed away this year were two past presidents of the Society—Dr. John H. Harris, Sr., and Dr. Louis W. Jones.

"From September 1, 1974, to August 31, 1975, we have lost by death 155 members: 11 not over 50 years of age; 59 between 51 and 70; and 85 in the group aged 71 to over 90. Of these 155 members, 69 were associates, most of whom

were 65 years of age or over. The necrology report at the last annual session reported the loss of 208 members.

"May we rise for this moment in silence and respect to those members who have passed to their eternal reward during the past year."

Change in Reference Committee Schedules

At this time the speaker drew the attention of the House members to the change in Reference Committee meeting times as recorded on the pink sheet included in the Delegates' Packet. Dr. Lovette went on to read the new reference committee meeting times to the House.

PaMPAC Presentation

R. William Alexander, M.D., Berks County, chairman of the PaMPAC board of directors, presented an informational report to the House. Dr. Alexander's remarks are attached as Appendix A.

Report from Pennsylvania Medical Cooperative

H. Robert Davis, M.D., Cumberland County, president of the Pennsylvania Medical Cooperative, presented a brief informational report to the House. He reported that the Pennsylvania Medical Cooperative is now operational, receiving and filling orders for its member-physicians. He drew the attention of the House to the Pennsylvania Medical Cooperative display outside the meeting room.

Announcements

D. Ernest Witt, M.D., Columbia County, vice speaker of the House of Delegates, introduced officers of the Society, members of the Judicial Council, and members of the Board of Trustees and Councilors.

Approval of Proceedings

The Proceedings of the 125th Annual Meeting of the Society in Pittsburgh, October 10-12, 1974, found on pages 66 through 112 in the December 1974 issue of PENNSYLVANIA MEDICINE, were approved.

Address of the President

A. Reynolds Crane, M.D., Philadelphia County, president, gave a report on his term as president, with emphasis on the professional liability insurance crisis. Recommendations made by Dr. Crane regarding new filings from all malpractice insurance carriers, the development of a captive insurance company, and the creation of a joint committee of the House and Board were referred to Reference Committee on Medical Service A. Recommendations concerning the composition of arbitration panels, the payment of punitive damages to the State, a letter on H.B. 1367 to legislative leaders, elimination of awards for pain and suffering, and contingency fees for pain and suffering were referred to the Reference Committee on Governmental Relations. A recommendation concerning interdiction of the application of PSRO data was referred to the Reference Committee on Medical Service B and the recommendation concerning unified membership in the AMA was referred to the Reference Committee on Constitution and Bylaws. The text of Dr. Crane's address appears as Appendix B of these proceedings.

Report of the AMA Delegation

As required by the resolved portion of Resolution 71-1: AMA Delegation Report on Plans, the House received a brief report from Malcolm W. Miller, M.D., Philadelphia, chairman of the PMS Delegation:

"Mr. Speaker, Members of the House of Delegates:

"I call your attention to the complete report of the Pennsylvania Delegation to the American Medical Association which appears on pages 80 to 83 of the *Official Reports Book*. My remarks today will be confined to those items which I believe should be emphasized.

"The Pennsylvania Medical Society was represented by a full complement of delegates at the Clinical Meeting of the AMA in Portland, Oregon, in December, 1974, and at the Annual Meeting in Atlantic City, New Jersey, in June, 1975. Your delegation continues to remain active and energetic in the organizational affairs of the parent organization.

"At the June meeting, Dr. William Y. Rial, of Swarthmore, was re-elected vice speaker of the AMA House of Delegates.

"I would like to call to your attention the fact that Dr. Wilbur E. Flannery, of New Castle, has requested not to be renominated as a delegate to the AMA. Dr. Flannery served as an alternate for six and one-half years, and a delegate for three and one-half years. Also, Dr. H. Robert Davis, Jr., of Boiling Springs, has requested not to be renominated as an alternate delegate. He served on the delegation for one and one-half years.

"The contributions of these physicians, not only in the Pennsylvania Medical Society but at the AMA level, have been invaluable and they will be missed as members of the Pennsylvania Delegation and should receive the plaudits of this House of Delegates.

"As noted in our report, two resolutions mandated by this House and one mandated by our Board of Trustees were introduced at the Clinical Meeting and two resolutions were introduced by our delegation and one by a delegate during the Annual Meeting.

"As you know, many key issues were discussed during the Portland and Atlantic City meetings and will be reviewed during the open hearing of our delegation scheduled for tomorrow morning, Tuesday, at nine o'clock in this room. Everyone is welcome and I personally urge you to attend to let us have the benefit of your comments, opinions, and perhaps any questions that occur to you."

Pennsylvania Delegation Open Hearing

It was announced that the Pennsylvania Delegation to the AMA would hold an open hearing Tuesday morning at 9:00 a.m. in the Baroque Ballroom with the Pennsylvania Delegation sitting as a special committee, Dr. Miller, chairman, presiding. The purpose of the hearing was to afford the members an opportunity to ask questions of the delegation and to make known their views on the AMA.

Distinguished Guests

The following distinguished guests were presented to

the House: Jack Leckie, M.D., president, West Virginia State Medical Association; Karl F. Mech, M.D., president, Medical and Chirurgical Faculty of Maryland.

Address of the President Elect

David S. Masland, M.D., Cumberland County, president elect, presented a report on his plans for the coming year. Dr. Masland's speech, including the recommendation regarding a medical defense unit, was referred to the Reference Committee on Reports of Officers, with the exception of the recommendation concerning implementation of the patient-physician contract, which was referred to the Reference Committee on Medical Service A. The text of Dr. Masland's address appeared in the November issue of PENNSYLVANIA MEDICINE, beginning on page 32.

Acceptance of Reports and Resolutions

The material contained in the 1975 *Official Reports Book* was presented for acceptance to the House.

The speaker recognized the delegate on the floor of the House, who spoke in favor of withdrawing Resolution 75-12, because of its possible effects on the Society's tax exempt status.

Motion: It was properly moved and seconded that Resolution 75-12 be withdrawn. *Motion carried.*

The remainder of the material in the *Official Reports Book* was accepted.

The following announcement was made with regard to the Pennsylvania Medical Care Foundation: "As you know, according to the Bylaws of the Medical Care Foundation, the members of the PMS House of Delegates are also the administrative members of the Pennsylvania Medical Care Foundation. In the packet you will find the 1975 Annual Report of the board of directors of the Pennsylvania Medical Care Foundation. It is referred to the Reference Committee on Medical Service B. It is the recommendation of the speaker that the House determine to hold the annual meeting of the Pennsylvania Medical Care Foundation tomorrow afternoon. We recommend that immediately after concluding the Reference Committee on Constitution and Bylaws, the House consider the Reference Committee Report on Medical Service B. At the conclusion of Medical Service B we believe the House should recess and immediately reconvene the meeting of the administrative members of the foundation. Following the annual meeting of the foundation, we would reconvene as the House of Delegates and continue with nominations and/or elections."

The speaker called upon Matthew Marshall, Jr., M.D., Allegheny County, president of the Pennsylvania Medical Care Foundation, for a few remarks concerning the annual report of the foundation.

The following supplemental reports were contained in the *Official Reports Book*. They became the official business of the House. (1) Supplemental Report A, Board of Trustees and Councilors (Referred to Reference Committee on Reports of Officers). See Appendix C. (2) Supplemental Report B, Board of Trustees and Councilors (Referred to Reference Committee on Professional Relations and Services). See Appendix D. (3) Supplemental Report C, Board of Trustees and Councilors (Referred to Reference Committee on Reports of Officers). See Appendix E. (4) Supplemental Report D, Board of Trustees and Councilors, (Referred to Reference Committee on Reports of Officers). See Appendix F. (5) Supplemental Report E, Board of Trustees and Councilors (Referred to Reference Committee on Medical Service A). See Appendix G. (6) Supplemental Report F, Board of Trustees and Councilors, (Referred to Reference Committee on Reports of Officers). See Appendix H.

The following supplemental reports in the delegates packets were received as the business of the House. (1) Supplemental Report G, Board of Trustees and Councilors (Referred to Reference Committee on Medical Service A). See Appendix I. (2) Supplemental Report H, Board of Trustees and Councilors (Referred to Reference Committee on Medical Service A). See Appendix J. (3) Supplemental Report I, Board of Trustees and Councilors (Referred to Reference Committee on Medical Service A). See Appendix K. (4) Supplemental Report J, Board of Trustees and Councilors (Referred to Reference Committee on Reports of Officers). See Appendix L. (5) Supplemental Report, Council on Governmental Relations (Referred to Reference Committee on Governmental Relations). See Appendix M. (6) Supplemental Report, Committee on Relationships with Allied Professions (Referred to Reference Committee on Education and Science). See Appendix N. (7) Supplemental Report, Council on Professional Relations and Services (Referred to Reference Committee on Professional Relations and Services). See Appendix O. (8) Annual Report of the Educational and Scientific Trust (Referred to Reference Committee on Education and Science). Available upon request. (8) Report of Pennsylvania Blue Shield (Referred to Reference Committee on Medical Service A). Available upon request. (9) Budget calculations for 1976 (Referred to Reference Committee on Reports of Officers). Available upon request.

Finance Committee Report

Ralph K. Shields, M.D., Northampton County, chairman, Finance Committee, presented the following report of the Finance Committee of the Board of Trustees and Councilors, which was referred to the Reference Committee on Reports of Officers:

"A copy of the proposed budget of 1976 as approved by the Board of Trustees has been distributed for your information. It also contains the comparative figures of the budget approved for 1975, as well as the actual expenditures for the period January 1 through August 31, 1975, which shows a surplus of $118,675. The largest contributing factor to this surplus was the foresight of the House of Delegates in approving a $50 dues increase for 1975 rather than the $25 requested by the chairman of the Finance Committee at the last session. This gave us an additional $270,000 to work with, and were it not for the availability of these funds we would be faced with a sizable deficit since it was necessary to budget a considerable sum to cover expenses in connection with the malpractice problem. We have also been fortunate in receiving good returns on short term investments. In addition, the Regional Medical Program was continued for a full year rather than being phased out on June 30 of this year as was anticipated at

the time the 1975 budget was being prepared. If the malpractice problem is cleared up without the need for spending the additional funds which were budgeted, we could end the year 1975 with a surplus of approximately $200,000.

"The 1976 budget is based on the current annual assessment of $150 per full dues paying member and reflects a surplus of $147,577. It includes reimbursement from the Federal Government for a six month period since we have once again been advised that Regional Medical Programs will be terminated as of June 30, 1976.

"The 1976 budget has been reviewed in depth and a number of changes have been made. The Finance Committee and the Board of Trustees believe the requests of the various councils, committees, and departments are reasonable and represent the funds needed to carry out currently mandated programs. Great care in spending has been exercised in the past and we solicit the continued cooperation of all units of the Society in this respect.

"I would like to make a few comments on a couple of resolutions which will be considered by this House of Delegates. Resolution No. 75-1 speaks to the policy of transportation reimbursement, with a possible saving to the Society of $1,800. Currently, all authorized travel is reimbursed at first class rates. This resolution would change that policy to travel reimbursement at coach rates. The Finance Committee recommended, and the Board has approved, that the future policy of the Society would provide for reimbursement at coach rates for transportation for anyone traveling on Society business.

"Resolution No. 75-13, if approved, would provide for reimbursement by the Pennsylvania Medical Society to delegates attending emergency sessions of this House of Delegates. This carries with it a price tag of approximately $35,000 for one two day session.

"In addition, if the malpractice problem should be continued into 1976 we will need to allocate funds to meet the expenses which would be incurred in such a situation. Other problems which could substantially affect the fate of the budget is the extent of our financial commitment to battling proposed comprehensive health planning legislation and possible lawsuits.

"Also, Resolution No. 75-23 for a biannual meeting of the PMS Councils on Governmental Relations and Medical Service with the legislative caucus of the State of Pennsylvania in Washington, D.C., carries a price tag of $8,500; and Resolution No. 75-28 which would do away with the requirement of Doctors of Osteopathy to be members of the State Society if they are already members of the Pennsylvania Osteopathic Society could reduce the income by $7,500.

"However, as it stands today, it appears that no increase in dues will be necessary for 1976. A recommendation will be made at the last session of the House after all actions have been carefully reviewed.

"If there are any questions regarding the budget or the financial condition of the Society, I strongly urge you to attend the hearing of the Reference Committee on Reports of Officers where members of the Finance Committee will be available to hear your opinion and attempt to answer any questions you might have. Thank you."

Resolutions

The following resolutions were received less than thirty days before the meeting of the House of Delegates and were accepted by the House as business:

Resolution 75-15

Subject: Petition to Social Security Administration Regarding Notification to Physician When Medicare Payment Is Sent to the Patient
Introduced by: Ulysses E. Watson, M.D., chairman, Montgomery County Medical Society delegation
Author: Joseph L. Hunsberger, M.D.
(Referred to Reference Committee on Medical Service A)

Resolution 75-16

Subject: Malpractice Rating
Introduced by: Sidney A. Parsons, Jr., M.D., secretary, Delaware County Medical Society
Author: Sidney A. Parsons, Jr., M.D.
(Referred to Reference Committee on Medical Service A)

Resolution 75-17

Subject: Repeal of the Bennett Amendment of Public Law 92-603
Introduced by: John D. Lane, M.D., delegate, on behalf of the Bucks County Medical Society
Author: John D. Lane, M.D.
(Referred to Reference Committee on Medical Service B)

Resolution 75-18

Subject: Protection of Physician-Patient Confidentiality
Introduced by: H. Robert Davis, M.D., secretary, on behalf of the Cumberland County Medical Society
Author: H. Robert Davis, M.D.
(Referred to Reference Committee on Medical Service A)

Resolution 75-19

Subject: Blue Shield Fees
Introduced by: O. K. Stephenson, M.D., secretary, on behalf of the Perry County Medical Society
Author: O. K. Stephenson, M.D.
(Referred to Reference Committee on Medical Service A)

Resolution 75-20

Subject: "Vendors" of Service
Introduced by: Edward J. Resnick, M.D., on behalf of the Philadelphia County Medical Society
Author: Paul M. Lin, M.D.
(Referred to Reference Committee on Medical Service A)

Resolution 75-21

Subject: Legislative Action Requiring Documented Medical Evidence for the Performance of Abortion
Introduced by: John D. Lane, M.D.
Author: John D. Lane, M.D.
(Referred to Reference Committee on Education and Science)

Resolution 75-22

Subject: Expulsion of the Professional Expert Witness from the Pennsylvania Medical Society
Introduced by: Robert W. Allen, M.D., secretary, Mercer County Medical Society
Author: Robert W. Allen, M.D.
(Referred to Reference Committee on Medical Service A)

Resolution 75-23

Subject: Petition to Recommend Biannual Meeting of PMS Council on Governmental Relations and Council on Medical Service with the Legislative Caucus of the State of Pennsylvania in Washington, D.C.
Introduced by: John L. Steigerwalt, M.D., delegate, Montgomery County Medical Society
Author: John L. Steigerwalt, M.D.
(Referred to Reference Committee on Governmental Relations)

Resolution 75-24

Subject: Regionalization of the Activities of the Joint Commission on Accreditation
Introduced by: Joseph V. Caliguiri, M.D., secretary, on behalf of the Allegheny County Medical Society
Author: Matthew Marshall, Jr., M.D.
(Referred to Reference Committee on Education and Science)

Resolution 75-25

Subject: Payment for Protective Custody of "Battered Children"
Introduced by: George R. Fisher, M.D., on behalf of the Philadelphia County Medical Society
Author: George R. Fisher, M.D.
(Referred to Reference Committee on Medical Service B)

Resolution 75-26

Subject: Peer Review
Introduced by: Henry H. Fetterman, M.D.
Author: Henry H. Fetterman, M.D.
(Referred to Reference Committee on Medical Service B)

Resolution 75-27

Subject: Proposed Amendments to the Constitution of the Pennsylvania Medical Society Concerning the Procedure of Electing Trustees and Councilors
Introduced by: Edgar W. Kline, M.D., delegate, Montgomery County Medical Society
Author: Edgar W. Kline, M.D.
(Referred to Reference Committee on Reports of Officers)

Resolution 75-28

Subject: Doctors of Osteopathy Being Members of County Medical Societies and not Members of Pennsylvania Medical Society
Introduced by: Irving Williams, M.D., on behalf of the Union County Medical Society
Author: J. Preston Hoyle, M.D.
(Referred to Reference Committee on Constitution and Bylaws)

Resolution 75-29

Subject: Opposing Primary Eye Care by Optometrists
Introduced by: H. Robert Davis, M.D., secretary, Cumberland County Medical Society
Author: Paul A. Cox, M.D.
(Referred to Reference Committee on Medical Service A)

Resolution 75-30

Subject: Laboratory Regulations
Introduced by: Joseph V. Caliguiri, M.D., Allegheny County Medical Society
Author: James A. Nicotero, M.D.
(Referred to Reference Committee on Medical Service A)

Resolution 75-31

Subject: Mandatory Insurance Provisions
Introduced by: John Helwig, M.D., delegate, Philadelphia County Medical Society
Author: John Helwig, M.D.
(Referred to Reference Committee on Governmental Relations)

Resolution 75-32

Subject: Scheduling of Pennsylvania Medical Society Annual Session
Introduced by: Philip W. Hoovler, M.D.
Author: J. Scott Hommer, M.D.
(Referred to Reference Committee on Reports of Officers)

Resolution 75-33

Subject: Medical Malpractice
Introduced by: John Whiteley, M.D., secretary, York County Medical Society
Author: John Whiteley, M.D.
(Referred to Reference Committee on Governmental Relations)

Reference Committees

Reference Committees for the 1975 Annual Session of the House of Delegates are listed below:

Constitution and Bylaws

*Robert Poole, III, (Chester), Chairman
*John V. Blady (Philadelphia)
*Betty L. Cottle (Blair)
*John L. Kelly (Delaware)
*John P. Whiteley (York)
Charles L. Deardorff (Lancaster), Alternate

Education and Science

*Robert N. Moyers (Crawford), Chairman
*Edmund L. Housel (Philadelphia)
*Stanley P. Mayers, Jr. (Centre)

*Theodore A. Tristan (Dauphin)
*Ulysses E. Watson (Montgomery)
John H. Shugert (Beaver), Alternate

Credentials

J. Campbell Martin (Columbia), Chairman
David L. Miller (Clarion)
Howard L. Carbaugh (Lehigh)
David A. Smith (Dauphin)
Steven I. Dodd (Mifflin-Juniata)
Frank J. Tornetta (Montgomery), Alternate

Professional Relations and Services

*Henry H. Fetterman (Lehigh), Chairman
*Lester A. Dunmire (Allegheny)
*Sidney O. Krasnoff (Philadelphia)
*Edward A. Lottick (Luzerne)
*Clifford B. Lull (Jefferson)
Frederick G. Brown (Montour), Alternate

Governmental Relations

*Joseph N. Demko (Lackawanna), Chairman
*Norman A. Goldstein (Chester)
*Robert W. Allen (Mercer)
*R. Robert Tyson (Philadelphia)
*Virginia E. Washburn (Allegheny)
Leonard F. Schickling (Clearfield), Alternate

Reports of Officers

*Robert J. Carroll (Allegheny), Chairman
*Dominick Cruciani (Lackawanna)
*Conrad A. Etzel (Delaware)
*Carol N. Maurer (Venango)
*Donald E. Harrop (Chester), Alternate
Edwin M. Price (Somerset)

Tellers

Samuel F. Cohen (Montgomery), Chairman
Joseph F. Alcaro (Adams)
John G. Hallisey (Beaver)
John C. Cavender (Susquehanna)
Arlington A. Nagle (Berks)
James P. Argires (Lancaster)
Charles R. Sloan (Fayette), Alternate

Medical Service A

*John Helwig, Jr. (Philadelphia), Chairman
*Frank J. Dracos (Monroe)
*Paul J. Schaner (Allegheny)
*Robert B. Stuart (Erie)
*Irving Williams, III (Union)
Donald W. Mitchell (Cambria), Alternate

Medical Service B

*Michael P. Levis (Allegheny), Chairman
*R. William Alexander (Berks)
*Arthur C. Crovatto (York)
*Eugene W. Herron (Westmoreland)
*Charles K. Zug, III (Northampton)
David P. Morrison (Bucks), Alternate

Rules

*William A. Shaver (Lebanon), Chairman
*Gabriel M. Lizak (Schuylkill)
*Edward N. Moser (Lycoming)
*Arthur J. Patterson (Greene)
*James R. Regan (Northampton)
Paul A. Cox (Cumberland), Alternate

**Indicates those members who signed the report.*

Alternates to reference committees—Again this year the speaker appointed, along with the regular five members of each reference committee, one alternate. These alternates were so notified and received all pertinent materials relating to their reference committees. The purpose is to make available to the committee a substitute familiar with the material, in the event that one of the regular committee members is unable to attend the meeting.

Remarks of President of Woman's Auxiliary

Mrs. Raymond C. Grandon, president, Pennsylvania Medical Society Auxiliary, addressed the House and reported on the Auxiliary's extensive efforts to aid the Society's legislative program to solve the professional liability insurance crisis. Her remarks were referred to the Reference Committee on Professional Relations and Services. Available upon request.

Remarks of President of Woman's Auxiliary to the AMA

Mrs. Erle E. Wilkinson, president of the American Medical Association Auxiliary, addressed the House. Her remarks were received for information.

Councilor District Caucuses

It was announced that councilor district caucuses would be held Tuesday morning beginning at 10:30 a.m., with the locations listed on the back page of the *Official Reports Book*. It was noted that a room had been set aside for the specialty society delegates and American Medical Student Association delegates in which they could hold a caucus beginning at 9:30 a.m. On Wednesday morning, further time was reserved at 8:30 a.m. for the second round of district caucuses. Copies of reference committee reports were made available at the caucuses.

Adjournment

The opening session of the House adjourned at 4:00 p.m.

The Second Session of the House, October 7, 1975

The second session of the House was called to order at 1:05 p.m. in the ballroom of the Host Farm Motel, Lancaster. J. Campbell Martin, M.D., Columbia County, chairman, Committee on Credentials, reported a quorum present.

It was noted that Bedford, Carbon, Huntingdon and Wyoming counties were without representation in the House of Delegates, as were: Specialty Societies—Colon and Rectal Surgery, Plastic Surgery, Psychiatry and Urology; AMSA Chapters—Hershey, Jefferson, Temple, University of Pennsylvania, Hahnemann, and Medical College of Pennsylvania.

It was noted that Bedford, Carbon, Huntingdon, and states that: "If any component society is without any duly accredited voting member of the House of Delegates at any session thereof, then the Active, Senior Active, Intern or Resident member or members registered in attendance from that component society may select himself or one delegate from their number, as the case may be, who shall be the representative of that component society and shall serve in the place of an accredited delegate."

Members of the Society who shall qualify to fill one of the vacancies were instructed to report to the Credentials Committee to apply for the vacancies.

(Secretary's Note: There were no persons present who applied to fill the above mentioned vacancies.)

Reference Committee Constitution and Bylaws

Robert Poole, III, M.D., chairman, presented the following report of the committee:

Elimination of Campaign Restrictions (pages 13 and 56 of the *Official Reports Book*)

In recent years, active campaigning has occured and no efforts have been made to enforce the Bylaws prohibiting such activity. The American Medical Association has no restrictions against campaigning.

Mr. Speaker, We recommend approval of the Bylaws' changes to delete restrictions against campaigning.

Further, the committee recommends that the matter of campaign practices be referred to the Standing Committee on Constitution and Bylaws for further study.

We recommend further that curriculum vitae and policy opinions of candidates for office be made available in a uniform way to all delegates.

Physician's Recognition Award (pages 13 and 56 of the *Official Reports Book*)

Considerable discussion was conducted regarding continuing medical education and many persons attending the reference committee hearing felt that the quality should be upgraded. Some objection was raised to the compulsory nature of the program. It was noted, however, that the American Medical Association has moved its deadline for certification of continuing medical education to June 30, 1976.

Mr. Speaker, We recommend approval of the Constitution and Bylaws' changes which set the deadline for certifying continuing medical education as June 30, 1976.

(Secretary's Note: Following introduction of the Reference Committee's recommendation but before a vote was taken, the speaker recognized the sponsor of Resolution 75-2 [Deletion of Sections 5, 6, and 7 of the Bylaws of the Pennsylvania Medical Society re Mandatory Continuing Education as a Prerequisite for Membership]. This resolution had originally been referred to the Reference Committee on Constitution and Bylaws, with referral later changed to the Reference Committee on Education and Science. Sentiment was expressed in favor of consideration of the resolution at this time. The speaker ruled that such discussion would be in order, and opened the floor to discussion. Numerous delegates took part in the discussion of Resolution 75-2. Following discussion, it was moved and seconded that Resolution 75-2 be disapproved. This motion carried. A vote was then taken on the recommendation of the Reference Committee that the continuing education date be set as June 30, 1976. The recommendation was adopted.)

Removal of Unnecessary Language from Constitution and Bylaws (pages 13 and 57 of the *Official Reports Book*)

The language made necessary for changing the Judicial Council's term of office from five to three years is now obsolete.

Mr. Speaker, We recommend that the obsolete language concerning the terms of office of the Judicial Council be deleted.

Automatic Suspension to Cover Those Pleading Guilty and Nolo Contendere (pages 14 and 57 of the *Official Reports Book*)

The reference committee heard testimony from legal counsel as well as that from many delegates, and it is our feeling that after pleading quilty or nolo contendere it is possible that a physician may not be convicted. For this reason, we feel that automatic suspension should occur only after conviction by a court has been pronounced with finality.

Mr. Speaker, We recommend that the recommendations of the Standing Committee on Constitution and Bylaws be rejected and that the wording of the Bylaws covering automatic suspension remain unchanged.

Expansion of Privileges for Associate Members (page 14 and 57 of the *Official Reports Book*)

The delegates and reference committee agree that the current associate membership represents a poor reward for those members over 70 years of age who have been active in organized medicine for a continuous period of 30 years.

Mr. Speaker, the committee recommends the adoption of the amendments which allow associate members to vote, serve as officers, and serve as voting members on councils, commissions, and committees.

(Secretary's Note: The proposed amendment to expand privileges for associate members failed to win the necessary two-thirds vote.)

Reintroduction of Incorrectly Edited Amendments (pages 17 and 57 of the *Official Reports Book*)

Testimony heard from the reference committee hearing pointed out that entrance into organized medicine through the component society is one, but not the only, portal of entry. Many delegates felt that little information would be obtained from the State Board of Medical Education and Licensure or in written form from specific hospitals. Its pursuit would be cumbersome and time consuming. Biographical material ascertaining credentials from the American Medical Association as is now required should be sufficient.

Mr. Speaker, We recommend the rejection of the Bylaws' amendments to require additional formal inquiry on prospective members.

(Secretary's Note: The proposed Bylaws amendments to require additional formal inquiry on prospective members did not receive the necessary three-fourths vote and was not adopted.)

Resolution 75-28

Subject: Doctors of Osteopathy Being Members of County Medical Societies and Not Members of Pennsylvania Medical Society.

Introduced by: Irving Williams, M.D., in behalf of the Union County Medical Society

Author: J. Preston Hoyle, M.D.

WHEREAS, In many areas of the Commonwealth of Pennsylvania, Doctors of Medicine and Doctors of Osteopathy work side by side; and

WHEREAS, In some areas of the Commonwealth, Doctors of Osteopathy have been accepted as members of hospital medical staffs; and

WHEREAS, Under Medicare, Medicaid, Champus, Pennsylvania Blue Shield, and many, if not all, commercial insurance carriers, a "physician" is defined as a Doctor of Medicine or a Doctor of Osteopathy; therefore be it

RESOLVED, That a Doctor of Osteopathy can become a member of a component county medical society; and be it further

RESOLVED, That if a Doctor of Osteopathy is a member of the Pennsylvania Osteopathic Medical Association that he need not be mandated to join the Pennsylvania Medical Society; and be it further

RESOLVED, That not being a member of the Pennsylvania Medical Society, that he will not, therefore, enter any of the rights and privileges of Pennsylvania Medical Society membership.

Resolution 75-28 requests that osteopathic physicians who belong to the Pennsylvania Osteopathic Society do not need to belong to the Pennsylvania Medical Society when they join a county medical society. This proposal is contrary to our present rules concerning joint membership in the county and state societies. Furthermore, our present Bylaws draw no distinction between M.D.s and osteopaths and we would be reluctant to do so. A similar resolution was considered and rejected by the 1974 House of Delegates.

Mr. Speaker, we recommend the defeat of Resolution 75-28.

(Secretary's Note:The delegate introducing the resolution spoke from the floor asking that it be withdrawn. It was moved and seconded that the resolution be withdrawn. Motion carried.

Unified Membership (page 5 of Dr. Crane's Address)

Dr. Crane has stated: "I again recommend that this Society require AMA membership of all of its members that we may better cope with the increasingly dangerous restrictions placed upon the practice of medicine by an unresponsive and obsolescent legal system and a burgeoning bureaucracy."

The reference committee determined from those present by a show of hands that the majority favored approval of unified membership for the Pennsylvania Medical Society.

Mr. Speaker, the reference committee, with one dissenting vote, recommends the adoption of Dr. Crane's recommendation.

Representation of Hospital Medical Staff to County Medical Societies (page 57 of the *Official Reports Book*)

The reference committee and the delegates in attendance recognize that the representation of hospital medical staffs in county medical societies is a problem of variable complexion. Representation of all hospital medical staffs, however, should be a matter of prime concern for all county medical societies.

Mr. Speaker, it is the recommendation of the reference committee that the Pennsylvania Medical Society encourage where appropriate individual county medical societies to study their individual problems of hospital medical staff representation and endeavor to develop their own unique solution to any inequities that may exist.

Reference Committee Medical Service B

Michael P. Levis, M.D., chairman, presented the following report of the committee:

Mr. Speaker, the Reference Committee on Medical Service B has considered all of the reports, resolutions, recommendations, and actions listed in the index.

Resolution 75-17

Subject: Repeal of the Bennett Amendment of Public Law 92-603

Introduced by: John D. Lane, M.D., delegate, on behalf of the Bucks County Medical Society

Author: John D. Lane, M.D.

WHEREAS, It is not the function of government to do for a profession what the profession can do for itself; and

WHEREAS, Presently medical practice has ample quality control mechanisms including tissue committees, mortality conference and morbidity reviews, medical audit committees, utilization review committees and continuing medical education; and

WHEREAS, These stated mechanisms have the support of the grass roots physician without excessive government interference; therefore be it

RESOLVED, That the above review mechanisms, as presently practiced, have proven themselves to be superior methods for quality control of medical care; and be it further

RESOLVED, That funding of PSRO is a superfluous waste of our over-taxed dollar; and be it further

RESOLVED, That the Pennsylvania Medical Society actively seek repeal of the Bennett Amendment of Public Law 92-603; and be it further

RESOLVED, That this resolution be referred to the Pennsylvania Medical Society Delegates to the American Medical Association and be introduced and supported by that delegation at the next business session of the American Medical Association.

The Reference Committee heard extensive testimony on this resolution. While some of those who testified strongly advocated repeal of the Bennett Amendment on the basis that it unnecessarily interferes with the private practice of medicine, it was noted that the alternatives to Professional Standards Review Organizations are to allow fiscal intermediaries and state and Federal agencies to make decisions on medical necessity without the involvement of practicing physicians. It was also pointed out that the Bennett Amendment clearly provides practicing physicians with the statutory authority to make final decisions on the medical necessity and appropriateness of medical care. Your Reference Committee believes that the Society should continue to support the concept of peer review as set forth in the Bennett Amendment as a more effective utilization review and quality appraisal system than some possible alternatives.

Mr. Speaker, your Reference Committee recommends rejection of Resolution 75-17.

1975 Annual Report, Board of Directors, Pennsylvania Medical Care Foundation (Delegates' Packet)

During the past year the Foundation has effectively carried out its stated aims and the directives of the Pennsylvania Medical Society's House of Delegates. The benefits of the Foundation's efforts are now more evident to our members at the grass-roots level.

The committee considered the recommendation on page 3 to continue Federal funding of the PSRO Support Center. The committee believes approval of this recommendation is consistent with previous actions of the House.

Mr. Speaker, your Reference Committee recommends approval of the Foundation's recommendation, on page 3 of the Annual Report, which supports continued Federal funding of the Foundation's PSRO Support Center.

The recommended Bylaws change on page 6 of the Annual Report was considered. Testimony presented, including that of the Foundation's president, indicated that this change was both unnecessary and inappropriate.

Mr. Speaker, your Reference Committee recommends rejection of the recommendation of the Foundation's Board of Directors to change the term of office for Foundation officers.

Mr. Speaker, your Reference Committee recommends that the remainder of the Annual Report be filed.

Address of Matthew Marshall, Jr., M.D., president, Pennsylvania Medical Care Foundation (Distributed to House)

Recommendation No. 1, page 2

The Reference Committee believes that the Foundation should continue its efforts to assure that practicing physicians are appropriately involved in utilization review and quality appraisal programs as the most effective means of serving the interests of both the medical profession and the public. It was pointed out that it will be necessary for the Society to provide the Foundation with funds to continue these activities.

Mr. Speaker, your Reference Committee recommends that the Foundation's request for funding in the president's address be referred to the PMS Board of Trustees for consideration.

Recommendation No. 2, page 2

The Reference Committee concurs with this recommendation. It is vital that the PSRO program be fully funded in order that physicians may have the opportunity to exercise the statutory authority granted by the law to make decisions regarding the necessity and appropriateness of medical care.

Mr. Speaker, your Reference Committee recommends approval of Recommendation No. 2 which supports adequate Federal funding of the PSRO program.

Recommendation No. 3, page 3

The Reference Committee was impressed that the Foundation has effectively carried out earlier directives of the House and should be urged to continue such activities.

Mr. Speaker, your Reference Committee recommends approval of Recommendation No. 3 reaffirming responsibility of the Foundation for developing satisfactory peer review programs.

Recommendation No. 4, page 3

Testimony presented supported the president's recommended Bylaws change.

Mr. Speaker, your Reference Committee recommends that the House of Delegates urge the administrative members of the Foundation to amend Article V-Board of Directors, Section 1. Composition of Board of Directors of the Foundation's Bylaws by adding the following sentence on page 3, at the end of line 7:

The chairman of the PMS Council on Medical Service shall serve on the board of Directors of this corporation as an ex-officio member with vote.

Address of A. Reynolds Crane, M.D., President, Pennsylvania Medical Society, recommendation on application of PSRO data, page 3 (distributed to House)

Your reference committee heard much testimony concerning the importance of maintaining the confidentiality of specific patient data. It was noted that P.L. 92-603 specifically prohibits release of patient information by the PSRO organization except for purposes of carrying out the specific intent of the law. Indeed the most stringent penalties in the PSRO law relate to violation of confidentiality of patient records.

However, additional testimony revealed that the president's recommendation refers to the norms, standards, and criteria developed by PSROs. It was noted that such material is correctly in the public domain and is not difficult to obtain. It was also pointed out that access to such norms, standards, and criteria may be beneficial to the defendant in medical malpractice proceedings, since it establishes "community" standards instead of national standards.

Mr. Speaker, your Reference Committee recommends rejection of the President's recommendation.

(Secretary's Note: The speaker brought to the attention of the House the fact that this question, originally referred to the Reference Committee on Governmental Relations, was also considered by the Reference Committee on Medical Service B. He suggested waiting until the report of the Reference Committee on Governmental Relations for discussion of the issue. The House adopted this recommendation.)

Resolution 75-9

Subject: Cooperative Peer Review Development
Introduced by: Howard L. Carbaugh, M.D., secretary, on behalf of the Lehigh County Medical Society
Author: Henry H. Fetterman, M.D.

WHEREAS, PSRO has developed into an integral, federally mandated factor in the delivery of medical care; and

WHEREAS, Physician control is essential in the evolution and function of PSRO; therefore be it

RESOLVED, That the Pennsylvania Medical Society introduce a resolution at the Clinical Session of the American Medical Association to reestablish the policy of appointing members to the Board of AAPSRO (American Association of Professional Standards Review Organizations), thereby allowing the AMA to contribute, monitor and develop the PSRO program.

Mr. Speaker, your Reference Committee recommends approval of Resolution 75-9.

Resolution 75-25

Subject: Payment for Protective Custody of "Battered Children"
Introduced by: George R. Fisher, M.D., in behalf of the Philadelphia County Medical Society
Author: George R. Fisher, M.D.

WHEREAS, The Pennsylvania Department of Welfare currently denies payment to hospitals for the protective custody of "battered children" during the period required to investigate their home situation and/or arrangement for foster homes (DPA Program Manual Section 9421.45 (b) and 9421.52 (g) defines this to be Department policy); and

WHEREAS, Section 1151 of the 1972 Bennett Amendment to the Social Security Act provides that it shall be the sole prerogative of PSRO's to determine which services are medically necessary; therefore be it

RESOLVED, That the House of Delegates direct the Foundation for Medical Care, to whom it delegates such responsibilities, to investigate, negotiate and seek to change DPW policy with regard to payment for "battered children;" and be it further

RESOLVED, That the Foundation be directed to warn Pennsylvania PSROs that they should not relinquish their legal authority in such matters through Memorandum of Understanding or in other ways; and be it further

RESOLVED, That suitable resolution be introduced to the American Medical Association House of Delegates encouraging other states to adopt similar policies for the assistance of disadvantaged children so affected.

Testimony indicated that this resolution was intended to point out the arbitratory policies of a government health agency to limit expenditures without regard to the welfare of the patient. These policies are in direct conflict with the intent of the PSRO Law.

While the committee is sympathetic with the intent of this resolution and the specific problem it addresses, we are concerned that a precedent of reimbursement of hospitals for purely domiciliary care may have far reaching implications. This is a complex problem which requires a well planned solution.

Mr. Speaker, your Reference Committee recommends that Resolution 75-25 be referred to the Council on Medical Service for action.

Resolution 75-26

Subject: Peer Review
Introduced by: Henry H. Fetterman, M.D., delegate, Lehigh County
Author: Henry H. Fetterman, M.D.

WHEREAS, It has been demonstrated that the delivery of good quality medical care can best be evaluated by peer review systems sponsored by practicing physicians; and

WHEREAS, Non-professional organizations have developed their own review systems to judge the appropriateness of physicians' services under the label of

"peer" review; therefore be it

RESOLVED, That the Pennsylvania Medical Society reassert its position that the best interests of the public and the profession can be served by recommending that its members participate only in medical review programs sponsored or approved by organizations representing practicing physicians; and be it further

RESOLVED, That the Pennsylvania Delegation be directed to introduce a similar resolution at the AMA 1975 Clinical Session.

Mr. Speaker, your Reference Committee recommends adoption of Resolution 75-26.

Elections

Nominations and elections were held Tuesday afternoon, October 7, 1975. The following officers were elected.

President: David S. Masland, M.D., (Cumberland) acceded to the office of president

President Elect: William J. Kelly, M.D., (Allegheny) acceded to the office of president elect

Vice President: John V. Blady, M.D., (Philadelphia)

Secretary: G. Winfield Yarnall, M.D., (Dauphin)

Speaker: John B. Lovette, M.D., (Cambria)

Vice Speaker: D. Ernest Witt, M.D., (Columbia)

The following Trustees and Councilors were elected:

Third District: Richard L. Huber, M.D., (Lackawanna)

Ninth District: Carol N. Maurer, M.D., (Venango)

Two members were elected to serve on the Committee to Nominate Delegates and Alternates to the AMA. They are: John V. Blady, M.D., (Philadelphia) elected to a full three year term; Charles K. Zug, III, M.D., (Northampton) elected to a full three year term.

George E. Farrar, Jr., M.D., and Russell B. Roth, M.D., were both elected to three year terms on the Judicial Council; this is the second year term for each.

The following district censors were elected for a one year term:

Adams, **James Allison;** Allegheny, **William D. Stewart;** Armstrong, **Arthur R. Wilson;** Beaver, **Herman Bush;** Bedford, **G. L. Rinard;** Berks, **Brian A. Wummer;** Blair, **John W. Hurst;** Bradford, ; Bucks, **Stanley F. Peters;** Butler, **Robert C. McCorrey;** Cambria, **Warren F. White;** Carbon, ; Centre, **H. Richard Ishler;** Chester, **Grant W. Bamberger;** Clarion, **Theodore R. Leonig;** Clearfield, **Fred Pease;** Clinton, **George J. Treires;** Columbia, **James F. Youngkin;** Crawford, **David D. Kirkpatrick, Jr.;** Cumberland, **Hans S. Roe;** Dauphin, **Robert P. Dutlinger;** Delaware, **Richard W. Garlichs;** Elk-Cameron, **Robert J. Dickinson;** Erie, **Robert L. Loeb;** Fayette, **Veronica Binns;** Franklin, **Albert W. Freeman;** Greene, **David L. Avner;** Huntingdon, **Thomas P. Mainzer;** Indiana, **Stephen J. Takach;** Jefferson, **Nicholas F. Lorenzo;** Lackawanna, **Norman S. Berger;** Lancaster, **William G. Phippen;** Lawrence, **Gerald H. Weiner;** Lebanon, **C. Ray Bell, Jr.;** Lehigh, **Frederick A. Dry;** Luzerne, **Samuel T. Buckman;** Lycoming, **Franklin G. Wade;** McKean, **Bruno P. Sicher;** Mercer, **Frank E. McElree;** Mifflin-Juniata, **Donald E. Basom;** Monroe, **Claus G. Jordan;** Montgomery, **Rudolph K. Glocker;** Montour, **Robert L. Gatski;** Northampton, **Walter J. Filipek;** Northumberland, **J. Mostyn Davis;** Perry, **James O. Rumbaugh, Jr.;** Philadelphia, **Charles M. Thompson;** Potter, **H. C. Mosch;** Schuylkill, **Joseph T. Marconis;** Somerset, **Alexander Solosko;** Susquehanna, ; Tioga, **Lane H. Webster;** Union, **Joseph Weightman;** Venango, **Robert L. Taylor;** Warren, **Donald Jack Furman;** Washington, **Joseph N. McMahan;** Wayne-Pike, **Emil T. Niesen;** Westmoreland, **Leslie S. Pierce;** Wyoming, **John S. Rinehimer, Jr.;** York, **Donald R. Gross.**

(Secretary's Note: It was noted that the Board of Trustees has the power to fill vacancies with regard to district censors.)

Report of the Committee to Nominate Delegates and Alternates to the AMA

The speaker introduced the subject of delegates and alternates to the American Medical Association. The recommendations of the Committee to Nominate Delegates and Alternates to the American Medical Association were contained in the Official Call, published on page 43 of the July 1975 issue of PENNSYLVANIA MEDICINE, on page 12 of the *Official Reports Book*. Elected to two year terms, beginning January 1, 1976, and expiring December 31, 1977, were:

Paul S. Friedman, M.D., (Philadelphia County)
John B. Lovette, M.D., (Cambria County)
Matthew Marshall, Jr., M.D., (Allegheny County)
Malcolm W. Miller, M.D., (Philadelphia County)
Robert N. Moyers, M.D., (Crawford County)

Five alternate delegates were elected for two year terms, beginning January 1, 1976, and expiring December 31, 1977:

Lawrence D. Ellis, M.D., (Allengheny County)
Henry H. Fetterman, M.D., (Lehigh County)
Wayne W. Helmick, M.D., (Beaver County)
John H. Helwig, Jr., M.D., (Philadelphia County)
David J. Keck, M.D., (Erie County)

Distinguished Guests

The following distinguished guests were presented to the House: Mr. Ben Badman, Jr., chairman, Hospital Association of Pennsylvania; Miss Jacqueline Fehling, speaker of the House of Delegates, Pennsylvania Society, American Association of Medical Assistants; and Dr. Daniel A. Hussar, president, Pennsylvania Pharmaceutical Association.

Reference Committee Governmental Relations

Joseph N. Demko, M.D., chairman, presented the following report of the committee:

President's Address—Recommendation Concerning Let-

ter from the Society's House of Delegates to the Pennsylvania House of Representatives (Delivered Verbally)

The reference committee heard much testimony concerning the inadequacies of H.B. 1367 and its failure to properly address the root causes of the medical liability crisis. Testimony was also heard as to the desirability of getting H.B. 1367 enacted promptly as a "building block," or, more appropriately a law (although an inadequate law) on which to enlarge. Accordingly, your reference committee recommends that the following letter be sent to the members of the Pennsylvania House of Representatives to be signed by the speaker of the House of Delegates at a time agreed upon by the speaker of the House of Delegates and the Executive Committee of the Board of Trustees:

"The Pennsylvania Medical Society reluctantly—and with great disappointment—requests the Pennsylvania House of Representatives to accept the Senate amendments to House Bill 1367 (P.N. 2273). We ask for immediate action so that we can get about the business of modifying and improving this small, first step.

"The malpractice bill was not designed by the Pennsylvania Medical Society; it does not represent the position of organized medicine. It offers no real, long-term answers to the crisis in heatlh care. The final version before you goes significantly beyond concessions to which the Society reluctantly acquiesced in order to get some short-range relief in a major emergency.

"We recognize that the General Assembly and the Administration have searched assiduously for a solution. We thank those who have tried to help.

"No legislative proposal will work that doesn't provide for a reasonable limit on outrageous, sky-high awards, doesn't establish final, binding arbitration, and doesn't attack other pernicious provisions in the present system.

"The Pennsylvania Medical Society will support corrective legislation (as soon as the General Assembly returns in January) to bring about true reform, seeking approval of such measures as:

- Revision of the panel composition to give physicians fair and equitable membership;
- Elimination of the improper use of PSRO norms, standards and criteria;
- Provision that any punitive damages assessed go to the State Board of Medical Education and Licensure rather than allow unjust enrichment of the plaintiff or counsel;
- Fair limitation of lawyers' contingent fees;
- Setting a realistic statute of limitations;
- Binding arbitration;
- Limitation of awards to actual economic loss.

"Organized medicine will keep on working for the adoption of these and other proposals which offer meaningful, long-term solutions to the continuing crisis. Our job—and yours—has just begun."

Mr. Speaker, we recommend approval of the letter and the recommendations concerning its going forward.

President's Address—Item 2—Composition of Arbitration Panels and Application of PSRO Data (In Delegates' Packet)

Your reference committee heard much testimony on the inequities in the makeup of the arbitration panels as well as the use of PSRO's as spelled out in the bill, which, in your committee's opinion, is a misuse of the original concept. Your committee recommends that the President's recommendation on page 3, with the deletion of the following words from the second paragraph "and that until such time as that change is made, the PSRO activities and development be held in abeyance and HEW so notified" be referred to the Council on Governmental Relations for future legislative development.

Mr. Speaker, your Reference Committee recommends referral to the Council on Governmental Relations.

After this recommendation was made, the speaker of the House noted that the issue was considered by two reference committees, the Reference Committee on Governmental Relations and the Reference Committee on Medical Service B. He called on Michael P. Levis, M.D., chairman of the Reference Committee on Medical Service B, who came to the front of the room and read the recommendation of his reference committee that this proposal be rejected. The speaker asked if Dr. Levis' committee would accept the recommendation for referral as made by the Reference Committee on Governmental Relations. Dr. Levis replied that this would be acceptable. A vote was taken on the recommendation of the Reference Committee on Governmental Relations that this question be referred to the Council on Governmental Relations; the vote favored referral.

President's Address—Item 4—Concerning Punitive Damages Payable to the State (In Delegates' Packet)

The Reference Committee on Governmental Relations views Dr. Crane's recommendation on page 3 at the bottom of the page as very novel and very worthwhile, in which he recommends that punitive damages really constitute a fine, and, as such, belong to the State. Your reference committee recommends approval of his recommendation with the following amendment: After the word "state" at the end of line 3, insert "Board of Medical Education and Licensure." This recommendation is for the purpose of better enforcing the State's Medical Practice Act.

Mr. Speaker, your Reference Committee recommends approval of Dr. Crane's recommendation as amended and referral to the Council on Governmental Relations for implementation.

President's Address—Item 5—Re Elimination of Contingency Fee for Pain and Suffering (In Delegates' Packet)

Your Reference Committee agrees with Dr. Crane that this matter should be explored and eventually become the subject of remedial legislation.

Mr. Speaker, your Reference Committee recommends that this item be referred to the Council on Governmental Relations for further action.

Resolution No. 75-33

Subject: Medical Malpractice
Introduced by: John P. Whiteley, M.D., secretary, York County Medical Society
Author: John P. Whiteley, M.D.

WHEREAS, The medical malpractice crisis has not been resolved to the satisfaction of physicians practicing in Pennsylvania; and

WHEREAS, If present conditions continue it will be impossible to provide quality medical care to the citizens of Pennsylvania; therefore be it

RESOLVED, That the Pennsylvania Medical Society recommend and vigorously promote an amendment to the Constitution of Pennsylvania which limits awards and eliminates pain and suffering as per the Workmen's Compensation Act.

Mr. Speaker, your Reference Committee recommends adoption of Resolution 75-33, with the following amended resolve:

RESOLVED, That the Pennsylvania Medical Society recommend and vigorously promote legislation which limits awards and eliminates pain and suffering, as is done under the Workmen's Compensation Act.

Mr. Speaker, your Reference Committee recommends adoption of Resolution No. 75-33, as amended, and referral to the Council on Governmental Relations for implementation.

Resolution No. 75-31

Subject: Mandatory Insurance Provisions
Introduced by: John Helwig, M.D., delegate, Philadelphia County Medical Society
Author: John Helwig, M.D.

WHEREAS, The extremely high malpractice insurance premiums threaten to drive physicians out of Class 4 and 5 types of practice, and

WHEREAS, Some physicians seem willing to practice without malpractice insurance and to accept the personal financial risk in continuing to provide care to their patients; therefore be it

RESOLVED, That the Pennsylvania Medical Society not accept any proposed malpractice insurance act which includes a mandatory insurance provision.

The reference committee heard testimony aimed at the problems of the young physician with no means and the older physician seeing very few patients. Your committee was very sympathetic with the problems of the young physician and the retiring physician to which this resolution doesn't really direct itself. Accordingly, your reference committee feels that the resolution should be rejected, but that the problem of equitably covering the new physician and the physician who has limited his practice because of age or infirmity should be referred for study and recommendation to the Council on Medical Service.

Report of the Council on Governmental Relations *(Official Reports Book*, page 67)

The Reference Committee on Governmental Relations was pleased with the activity of the council as spelled out in their report, and urges them to "keep up the good work."

Mr. Speaker, your Reference Committee recommends that the report of the Council on Governmental Relations be filed.

Supplemental Report of the Council on Governmental Relations (In Delegates Packet)

The council reports on a number of other bills in which the Society has a real interest. Your reference committee has taken special notice of Senate Bill 10 and House Bill 853, the Administration-sponsored "Comprehensive Health Care Act." It is your reference committee's feeling that in many respects these bills and their contents represent a more significant threat to medical practice than our quest for a solution to the malpractice crisis. Accordingly, this House should once again go on record as denouncing all of the ingredients in these bills with the exception of a sensible "Certificate of Need" for Pennsylvania.

Mr. Speaker, your Reference Committee recommends strong opposition to Senate Bill 10 and House Bill 853 in their present form, and instructs the Council on Governmental Relations to respond appropriately.

Report of the Committee on Discipline *(Official Reports Book*, page 58)

The reference committee recommends that the report of the Committee on Discipline be filed.

Resolution No. 75-23

Subject: Petition to recommend biannual meeting of PMS Council on Governmental Relations and Council on Medical Service with the legislative caucus of the State of Pennsylvania in Washington, D.C.
Introduced by: John L. Steigerwalt, M.D., delegate, Montgomery County Medical Society
Author: John L. Steigerwalt, M.D.

WHEREAS, The insidious involvement of the Federal government into the delivery and practice of medicine has evolved so precipitously in the past decade; and

WHEREAS, The Federal government has begun to pay out large sums of money in payment for medical services rendered; and

WHEREAS, The Federal government has demanded accountability for the use of monies it pays out for these medical services in the form of a PSRO; and

WHEREAS, The Federal government is contemplating further and more comprehensive involvement into the practice and delivery of medical care in the form of P.L.

93-641 (National Health Planning and Resources Development Act, 1974) and national health insurance; therefore be it

RESOLVED, That the Council on Governmental Relations and the Council on Medical Service of the Pennsylvania Medical Society develop an educational program for the Pennsylvania Medical Society as it relates to governmental medical legislation with specific recommendations to be presented at a specified pre-arranged meeting with the legislative caucus of the State of Pennsylvania in Washington, D.C., on a biannual basis.

Your reference committee is interested in anything that will enhance our legislative posture both at the state and Federal levels and recommends Resolution No. 75-23, but, since it involves two councils of the Society, it should be referred to the Board of Trustees for implementation if administratively sound and economically possible.

Mr. Speaker, your Reference Committee recommends that Resolution No. 75-23 be referred to the Board of Trustees.

Reference Committee Reports of Officers

Robert J. Carroll, M.D., chairman, presented the following report of the committee:

Mr. Speaker, and members of the House of Delegates, the Reference Committee on Reports of Officers has considered all the items in the index.

Your Reference Committee has grouped the following items together in a waiver of debate list. In each instance, there was little or no testimony heard and the committee feels the item is of a noncontroversial nature.

Report of the Executive Vice President (*Official Reports Book*, pages 32-34) (File)

Report of the Secretary (*Official Reports Book*, pages 34-36) (File)

Report of the Treasurer (*Official Reports Book*, page 36) (File)

Report of the Chairman of the Finance Committee (File)

Report of the Accountant (*Official Reports Book*, pages 36-40) (File)

Report of the Committee on Objectives (*Official Reports Book*, pages 58-59) (File)

Report of the Pennsylvania Delegation to the AMA (*Official Reports Book*, pages 80-83) (File)

Supplemental Report C, Board of Trustees and Councilors (*Official Reports Book*, pages 83-84) (File)

Supplemental Report F, Board of Trustees and Councilors (*Official Reports Book*, pages 85-89) (File)

Supplemental Report J, Board of Trustees and Councilors (Distributed) (File)

Mr. Speaker, we recommend that these items be filed.

Report of Board of Trustees and Councilors *(Official Reports Book*, pages 18-31)

Your Reference Committee reviewed the entire comprehensive report of the Board of Trustees and Councilors. The following item deserves the attention of the House of Delegates.

The recommendation for the elimination of the individual reports of the trustees was discussed. From the comments and testimony received, your Reference Committee felt that there was a need for this method of reporting of activities affecting county medical societies and councilor districts.

Mr. Speaker, your Reference Committee recommends that the recommendation of the Board of Trustees for the elimination of the reports of the individual councilors be rejected and that these reports continue to be prepared for the information of the membership.

Mr. Speaker, your Reference Committee recommends that the report of the Board of Trustees be filed.

Individual Reports from the Trustees and Councilors *(Official Reports Book*, pages 41-54)

Your Reference Committee reviewed the individual reports of the Trustees and Councilors.

Special note was taken of the report of the trustee and councilor of the Eleventh District (page 53). The recommendations are:

1. It is my urgent hope that the Committee on Constitution and Bylaws will introduce changes for the organization which will strengthen the activity, and increase the visibility, of county medical societies in the day to day practice of medicine.
2. I propose, therefore, that county affiliates and the Pennsylvania Medical Society as a whole make every possible effort to enhance the individual and public benefits of membership in this organization.
3. I believe the continuing education requirement for physicians should be administered by the Medical Society, so that we do not "rubber stamp" determinations made by any specialty board or academic center. Through our own efforts primarily, it should be possible to develop a public image in which membership in the Society will, of itself, become a credential that indicates the highest possible qualification and training for an individual physician.

Mr. Speaker, your Reference Committee recommends referral of recommendation number one to the Committee on Constitution and Bylaws for implementation.

Mr. Speaker, we recommend referral of recommendation number two to the Council on Professional Relations and Services for implementation.

Mr. Speaker, we recommend referral of recommendation number three to the Council on Education and Science for implementation.

Mr. Speaker, your Reference Committee recommends that the individual reports from trustees and councilors be filed.

Supplemental Report A, Board of Trustees and Councilors (*Official Reports Book,* page 83)

The Board of Trustees has recommended that the 1979 Annual Business Session be held at the Penn Harris Motor Inn from Thursday, October 11, to Saturday, October 13, and that the 1980 Annual Business Session be held at the Penn Harris Motor Inn from Thursday, October 9, to Saturday, October 11.

Mr. Speaker, your Reference Committee recommends approval of the sites for the 1979 and 1980 House of Delegates.

Supplemental Report D, Board of Trustees and Councilors (*Official Reports Book,* pages 84-85)

Your Reference Committee considered Supplemental Report D of the Board of Trustees and Councilors. From the testimony received, we felt that the WATS line number was not widely known by the membership. We would suggest that this information be more generally disseminated among the membership, possibly the means of *Executive Report, Legislative Bulletin* or similar PMS publications.

Mr. Speaker, your Reference Committee recommends that Supplemental Report D of the Board of Trustees and Councilors be filed.

Resolution No. 75-1

Subject: Transportation Reimbursement Policy
Introduced by: Stanley P. Mayers, Jr., M.D., on behalf of the Centre County Medical Society
Author: Stanley P. Mayers, Jr., M.D.

WHEREAS, The current economic recession coupled with a serious inflation of costs and prices has created grave financial problems for all citizens and agencies in our country; and

WHEREAS, Professional associations have been particularly hard hit by these financial problems to the extent that the American Medical Association has found it necessary to enact a compulsory assessment on all members and the Pennsylvania Medical Society has been forced to increase membership dues; therefore be it

RESOLVED, That the Pennsylvania Medical Society take all possible measures to economize in its operations; and be it further

RESOLVED, That as one economy measure, the Pennsylvania Medical Society make it a policy to reimburse persons traveling at Society expense at coach rates for transportation costs rather than first class rates.

Your Reference Committee heard considerable discussion on this resolution. It was learned in the course of the hearing that this resolution did not have any relation to reimbursement to delegates and alternate delegates to the AMA and the bulk of the testimony was negative.

Mr. Speaker, your Reference Committee recommends that Resolution 75-1 be rejected.

Resolution No. 75-13

Subject: Reimbursement for Delegates Attending Emergency Meetings of the Pennsylvania Medical Society's House of Delegates
Introduced by: Edward J. Resnick, M.D., secretary, on behalf of the Philadelphia County Medical Society
Author: David S. Cristol, M.D.

WHEREAS, Emergency meetings of the House of Delegates of the Pennsylvania Medical Society may be called in the future as in the past; and

WHEREAS, It is necessary to obtain a representative number of Delegates; therefore be it

RESOLVED, That the Pennsylvania Medical Society budget funds to cover travel and lodging expenses for those that may take place in the future.

Your Reference Committee heard testimony from a number of participants and the weight of the testimony was negative.

Mr. Speaker, your Reference Committee, therefore, recommends the rejection of Resolution 75-13.

Resolution No. 75-27

Subject: Proposed Amendments to the Constitution of the Pennsylvania Medical Society Concerning the Procedure of Electing Trustees and Councilors
Introduced by: Edgar W. Kline, M.D., delegate, Montgomery County Medical Society
Author: Edgar W. Kline, M.D.

WHEREAS, At the present time, a nomination for a Trustee and Councilor from a Councilor District is accomplished with a candidate being nominated by the voting members in the House of Delegates from the Councilor District which the Trustee and Councilor represents; and

WHEREAS, On the other hand the election is accomplished with a candidate being elected by all the voting members present at the Annual Session of the House of Delegates; and

WHEREAS, The Trustee and Councilor should be truly representative of the district and constituency they serve; therefore be it

RESOLVED, That the autonomy and political independence of the local county medical societies be respected by having the Trustee and Councilor of each district representing said local county medical societies, nominated and elected only by the voting delegates from the said district at the annual session of the House of Delegates; and be it further

RESOLVED, That the Committee on Constitution and Bylaws be directed to present language to implement this resolution at the next annual session of the House.

Your Reference Committee noted that similar resolutions have been considered at previous annual sessions. Testimony received was against the resolution.

Mr. Speaker, your Reference Committee recommends rejection of Resolution 75-27.

Resolution No. 75-32

Subject: Scheduling of Pennsylvania Medical Society Annual Session
Introduced by: Phillip W. Hoovler, M.D.
Author: J. Scott Hommer, M.D.

WHEREAS, The meeting dates of the Pennsylvania Medical Society House of Delegates and the American Academy of Family Physicians Congress of Delegates and Annual Scientific Session have been superimposed on multiple occasions within the past ten years; and

WHEREAS, This has resulted in considerable inconvenience and expense to the Pennsylvania Medical Society members who are actively involved in both organizations, and in some instances has denied them the opportunity to participate in both annual meetings; and

WHEREAS, The American Academy of Family Physicians is the largest national medical speciality organization; and

WHEREAS, It is possible in the future that such conflict of meeting dates could affect every specialty organization represented in the Pennsylvania Medical Society House of Delegates; therefore be it

RESOLVED, That the program committee, staff, and Board of Trustees of the Pennsylvania Medical Society review the meeting dates of all major national medical speciality organizations and make every reasonable effort to avoid conflict of meeting dates when planning future Pennsylvania Medical Society annual meetings.

Testimony supported the merit of this resolution.

Mr. Speaker, your Reference Committee recommends adoption of Resolution 75-32.

Recommendation in Address of David S. Masland, M.D., President Elect, Regarding Medical Defense Unit (page 2)

Your Committee has reviewed the comprehensive address of the president elect, who has succeeded in delineating the problems and dangers facing medicine and our patients. We commend him for this address and consider the following action from the address:

I recommend that we develop a medical defense unit within the Society sufficiently financed to field a legal defense team second to none. The team would defend all doctors. I believe that it would take only one or two test cases for the message to get out to every plaintiff's attorney in the Commonwealth that we are no longer going to cave in on these non-meritorious suits. I recognize that this proposal involves some technical problems and requires coordination with the carriers. Nevertheless, I strongly recommend its approval.

Your Reference Committee concurs with the recommendation of the President Elect.

Mr. Speaker, we recommend that the Board of Trustees be authorized to pursue this recommendation.

Mr. Speaker, we recommend that the address of the president elect be filed.

Announcements

The speaker announced that the polls would open in the morning at 7:30 a.m., that Councilor District Caucuses would be held beginning at 8:30 a.m., 8:00 a.m. for the specialty caucus, and that the House meeting would be called to order at 9:30 a.m.

The House recessed at 5:05 p.m. until the State Dinner, scheduled to begin at 8:00 p.m. in the ballroom.

The 1975 State Dinner

The invocation was given by Wilbur E. Flannery, M.D., a past president of the State Society and, before becoming a physician, a minister.

Introduction of Guests

Dr. Crane began the introduction of guests at 9:30 p.m.: Dr. and Mrs. John B. Lovette, speaker, House of Delegates; Dr. and Mrs. Wilbur E. Flannery, past president, PMS; Dr. and Mrs. Leonard Bachman, Secretary of Pennsylvania Department of Health; Mrs. Erle E. Wilkinson, president, American Medical Association Auxiliary; Mrs. Richard T. Smith, president, Pennsylvania Medical Society Auxiliary; Dr. and Mrs. Jonathan E. Rhoads, recipient, PMS Distinguished Service Award; Dr. and Mrs. David S. Masland, president elect, PMS; Dr. Cyrus B. Slease, chairman, PMS Board of Trustees; Dr. and Mrs. William J. Kelly, vice president, PMS; Dr. and Mrs. John V. Blady, vice president elect, PMS; Dr. and Mrs. Ralph K. Shields, Retiring Trustee and Councilor; Dr. and Mrs. Raymond C. Grandon, immediate past president, Pennsylvania Medical Society Auxiliary (Mrs. Grandon was presented a gavel by the Pennsylvania Medical Society in recognition of her services as president of the Auxiliary); Dr. and Mrs. D. Ernest Witt, vice speaker, PMS House of Delegates; Mr. John F. Rineman, Executive Vice President, PMS.

Also presented were: Dr. and Mrs. Calvin B. Hearne, president of the Medical Society of Delaware; Dr. Karl F. Mech, president, Medical and Chirurgical Faculty of Maryland; Dr. Brook E. Brush, president, Michigan State Medical Society; Dr. and Mrs. John J. McGuire, president of the Medical Society of New Jersey; Dr. R. S. Emerson, president of the Medical Society of the State of New York; Dr. Maurice F. Lieber, president of the Ohio State Medical Association; Dr. and Mrs. Jack Leckie, president elect of the West Virginia State Medical Association; Dr. and Mrs. Alex J. McKechnie, president of the Pennsylvania Dental Association; Dr. and Mrs. Daniel A. Hussar, president of the Pennsylvania Pharmaceutical Association; Mr. and Mrs. Irwin Benjamin, president of the Pennsylvania Bar Association; Miss Jacqueline Fehling, speaker of the House of Delegates of the Pennsylvania Society, American Association of Medical Assistants; Dr. and Mrs. Harold F. White, president of the Pennsylvania Osteopathic Medical Association; Dr. John W. Simmons, president of the Keystone Medical Society; and Mr. and Mrs. Ben Badman, Jr., chairman of the Board of the Hospital Association of Pennsylvania.

Dr. Crane introduced the following past presidents: Dr. and Mrs. Thomas W. McCreary, Sr.; Dr. and Mrs. Daniel H. Bee; Dr. and Mrs. Wilbur E. Flannery; Dr. Richard A. Kern; Dr. and Mrs. William B. West; Dr. George E. Farrar, Jr.; Dr.

William A. Barrett; Dr. and Mrs. William A. Limberger; Dr. and Mrs. George P. Rosemond; Dr. and Mrs. Robert S. Sanford. Also introduced was Mr. Lester H. Perry, the retired executive director of the Pennsylvania Medical Society.

Benjamin Rush Awards

Dr. Ulysses E. Watson, chairman, Council on Professional Relations and Services, presented the group Benjamin Rush Award to the Susquehanna University Student Volunteer Program. Receiving the award for the program was Miss Nancy K. Musser, student coordinator. The Susquehanna University Student Volunteer Program received the award in recognition of its wide ranging community services including work with children and the elderly, recycling projects, blood donation and clothing collections. As many as 35 different projects have been operating simultaneously through the student volunteer program. It is unique among volunteer programs in American colleges and universities in that it has attracted a high percentage of the student body as participants.

The individual Benjamin Rush Award was presented to Mr. Roger A. Congdon, Sr., of Ulster, Bradford County. Mr. Congdon was recognized for his outstanding emergency medical activities, including the founding of a much-needed ambulance service in the tri-township area in which he lives, and the training of some 2,000 people in first aid. All of Mr. Congdon's activities are voluntary, performed in addition to his full time job.

Presentation of Plaques to Retiring Trustees

Dr. Crane presented Dr. Cyrus B. Slease a plaque honoring him for his twelve years of service on the Board of Trustees, including service as vice chairman and chairman of the Board. A plaque was presented to Dr. Ralph K. Shields in honor of his seven years of service on the Board of Trustees and Councilors, including recent service as chairman of the Finance Committee.

Presentation of Staff Awards

Dr. Slease presented staff service awards to Miss Velma McMaster and Mr. Robert Craig, both of whom have completed 25 years of service to the Pennsylvania Medical Society.

Installation and Oath of Office

Dr. Slease, chairman of the Board of Trustees, installed Dr. David S. Masland, Cumberland County, as the 126th President of the Pennsylvania Medical Society.

Presentation of Past President's Medallion

Dr. Slease presented the past president's medallion and plaque to Dr. A. Reynolds Crane, Philadelphia County, in tribute to his great efforts in behalf of the Pennsylvania Medical Society as its 125th President.

Presentation of Distinguished Service Award

Dr. Masland announced that his first official duty was a happy one, the presentation of the Pennsylvania Medical Society's Distinguished Service Award to Dr. Jonathan E. Rhoads, Philadelphia. Dr. Masland drew attention to the fact that this is only the sixth time the award has been presented since its creation in 1955. The presentation of the award is in honor of Dr. Rhoad's long and distinguished career as a surgeon and professor of surgery at the University of Pennsylvania School of Medicine and the Hospital of the University of Pennsylvania. Following presentation of the award, Dr. Rhoads addressed the audience on the recent history of medical practice in the United States.

Adjournment

The formal portion of the program adjourned at 11:15 p.m. Members and their guests were entertained until 12 p.m. by the Ray Bloch orchestra from New York City.

Third Session of the House
October 8, 1975

The third session of the House of Delegates was called to order in the ballroom of the Host Farm Motel, Lancaster, Wednesday, October 8, 1975, at 9:30 a.m.

The Credentials Committee reported a quorum was present.

The speaker closed the polls.

Reference Committee Medical Service A

John Helwig, Jr., M.D., chairman, presented the following report of the committee:

Mr. Speaker and members of the House of Delegates: The Reference Committee on Medical Service A has considered all of the reports and resolutions listed in the above index. Considerable testimony was received on most of the items listed. However, your reference committee has grouped the following items together in a Waiver of Debate list. In each instance, there was little or no testimony heard and the committee feels the item is of a non-controversial nature.

Report of the Council on Medical Service (*Official Reports Book*—pages 69-77) (Approve)

Report of Pennsylvania Blue Shield (In Delegates' Packet) (Approve)

Resolution 75-5: Department of Public Welfare Payments (*Official Reports Book*—page 93) (Approve)

Resolution 75-20: "Vendors" of Service (In Delegates' Packet) (Approve)

Resolution No. 75-4

Subject: Nursing Home Standards
Introduced by: Edward A. Lottick, M.D., on behalf of the Luzerne County Medical Society
Author: Edward A. Lottick, M.D.

WHEREAS, The Commonwealth of Pennsylvania Department of Public Welfare published and sent to the nursing homes in 1974 standards which required that all patients in these nursing homes be seen each month by a physician; and

WHEREAS, Many of these patients are receiving custodial care and do not require or desire such services; and

WHEREAS, The cost of such care must be borne either by public or private sources; and

WHEREAS, Such unnecessary care is a financial burden on either the private or public sector; and

WHEREAS, Arbitrary requirements for these monthly visits without indication preempts the judgment of the attending physician (and of the nursing personnel); and

WHEREAS, There is already in existence a severe medical manpower shortage; therefore be it

RESOLVED, That the Pennsylvania Medical Society go on record as opposing such arbitrary and flagrant misuse of governmental power; and be it further

RESOLVED, That the Pennsylvania Medical Society urge its members to repudiate the action of the Pennsylvania Department of Public Welfare, and to do all in its power to rescind such ruling.

Members of the reference committee heard no testimony pro or con on this resolution, but the reference committee sympathizes with the intent of the resolution.

Mr. Speaker, your Reference Committee recommends that Resolution 75-4 be referred to the Council on Medical Service for further study.

Resolution No. 75-6

Subject: Denied Medicaid Payments

Introduced by: Edward J. Resnick, M.D., secretary, on behalf of the Philadelphia County Medical Society

Author: Board of Directors, Philadelphia County Medical Society

WHEREAS, The appeal hearings for denial of Medicaid payments by the Department of Welfare of the Commonwealth of Pennsylvania require selectively some attending physicians to be present in person at the offices of the Department of Welfare. This is an undue intrusion of the physicians' professionalism; and

WHEREAS, When the Department of Public Welfare conducts appeal hearings in a hospital where more attending physicians are available to explain the hospital's utilization, it results in a higher percentage of denials being reversed; therefore be it

RESOLVED, That the Pennsylvania Medical Society strongly urge that the Department of Welfare administer its appeal hearings in a hospital once a certain number of cases have been accumulated for review in that hospital.

Mr. Glenn Johnson, director of the Bureau of Medical Assistance, Department of Public Welfare, was present and offered testimony indicating that there have been no significant new retroactive denials since October 1974. However, we understand that there is a considerable backlog, especially in the metropolitan areas.

Mr. Speaker, your Reference Committee recommends approval of Resolution 75-6.

Resolution No. 75-15

Subject: Petition to Social Security Administration Regarding Notification to Physician When Medicare Payment is Sent to the Patient

Introduced by: Ulysses E. Watson, M.D., chairman, Montgomery County Medical Society Delegation

Author: Joseph L. Hunsberger, M.D.

WHEREAS, It is a matter of record that a physician not accepting assignment of a Medicare case does not receive notice when a patient has been paid; and

WHEREAS, It is a matter of record that the third party payor, Blue Shield as agent for the Social Security Administration under Medicare, does notify the patient of the amount and the date a physician has been paid when he takes assignment; and

WHEREAS, The Medicare patient is not clearly and emphatically informed that the direct payment to him is for the physician's services; therefore be it

RESOLVED, That the Pennsylvania Medical Society shall propose through the proper channels that the regulations regarding the administration of Medicare be amended to specify that the physician be notified by a duplicate copy of the amount and date a patient has been paid for a medical bill rendered directly by the patient because the physician did not accept assignment; and be it further

RESOLVED, That the form accompanying the check to the patient remind the patient to check his records to see if the physician has been paid, and if not, this said check is for payment to the physician.

Your Reference Committee felt it would be appropriate to offer the following substitute Resolution:

RESOLVED, That the Pennsylvania Medical Society request a change in Medicare regulations to include notification to the physician of the amount and date of payment in non-assigned claims.

Mr. Speaker, your Reference Committee recommends rejection of Resolution 75-15 and adoption of the substitute Resolution.

Resolution No. 75-18

Subject: Protection of Physician-Patient Confidentiality

Introduced by: H. Robert Davis, M.D., secretary, on behalf of the Cumberland County Medical Society

Author: H. Robert Davis, M.D.

WHEREAS, The Ellsberg case has established, in law, the inviolate privacy of the patient-physician relationship; and

WHEREAS, Federal, State, and other non-governmental agencies do, without expressed permission, abridge this relationship in routine and cavalier fashion; therefore be it

RESOLVED, That the Pennsylvania Medical Society introduce legislation, at both the State and Federal levels, prohibiting the examination of any physician-patient record by any governmental or non-governmental agency, without the signed permission of both the patient and the physician.

Extensive testimony was heard in favor of this resolution and no negative testimony was heard. Much of the testimony established the wholesale dragooning of patients' charts by third parties as an example of the ultimate violation of confidentiality.

Mr. Speaker, your Reference Committee recommends approval of Resolution 75-18 and recommends that the Pennsylvania Delegation to the AMA strongly support the intent of the resolution.

Supplemental Report E of the Board of Trustees (*Official Reports Book*, page 85)

Extensive testimony from ophthalmologists and others pointed out the hazards inherent in allowing non-physicians to diagnose and treat diseases of the eye. The ophthalmologists appeared not to oppose the concept of Blue Shield providing a supplementary benefit which provides for the purchase of corrective lenses for groups wishing to purchase it, but were concerned about the implications of the Blue Shield term "Vision Care," which might be interpreted as including the diagnosis and treatment of diseases and injuries of the eye.

The reference committee recognizes that Blue Shield will implement this program, but was heartened that they expressed cooperation with the Pennsylvania Academy of Ophthalmology and Otolaryngology in developing their own eye care foundation.

Mr. Speaker, your Reference Committee recommends approval of Supplemental Report E.

Resolution No. 75-29

Subject: Opposing Primary Eye Care by Optometrists
Introduced by: H. Robert Davis, M.D., secretary, Cumberland County Medical Society
Author: Paul A. Cox, M.D.

WHEREAS, Public Law 92-641 assures a high quality of medical care for everyone in our nation; and

WHEREAS, It is the responsibility of physicians to provide a high quality of medical care; and

WHEREAS, The practice of medicine by other than medically trained and licensed practitioners except under the supervision of such qualified practitioners does not constitute good health care; and

WHEREAS, Optometrists in Pennsylvania propose to be the primary eye care practitioners under comprehensive health planning and thereby treat "Minor injuries and pathologies, etc."; and

WHEREAS, Optometrists are not qualified to treat eye infections or injuries by training or license; and

WHEREAS, This constitutes the practice of medicine without benefit of a medical education and is not in keeping with quality medical care; therefore be it

RESOLVED, That the Pennsylvania Medical Society vigorously oppose the concept of allowing non-medical persons to practice medicine; and be it further

RESOLVED, That the Pennsylvania Medical Society specifically oppose allowing optometrists to provide the primary level of eye care as proposed in their testimony submitted to the State Advisory Council for Comprehensive Health Planning on May 6, 1975.

The reference committee heard no testimony in opposition to this resolution.

Mr. Speaker, your Reference Committee recommends approval of Resolution 75-29.

Address of the President—Joint Committee of House and Board (In Delegates' Packet)

Extensive testimony was heard in favor of the concept of setting up such a committee to explore every eventuality which may be necessary in dealing with government, third parties and any other exigency requiring a united front in a most organized manner.

The reference committee concluded that the intent of all the testimony would best be accomplished by having the House recommend the establishment of a Presidential Task Force, with the majority of the task force comprised of members of the Board of Trustees and the House of Delegates.

Mr. Speaker, your Reference Committee recommends referral of this recommendation to the Board of Trustees for the establishment of a Presidential Task Force.

Address of the President Elect—Patient Contract (In Delegates' Packet)

Your reference committee heard extensive testimony in strong support of the patient contract concept and recommends continued delineation and development of a patient contract in cooperation with the Hospital Association of Pennsylvania.

Mr. Speaker, your Reference Committee recommends approval of this recommendation from the address of the president elect.

Resolution No. 75-30

Subject: Laboratory Regulations
Introduced by: Joseph V. Caliguiri, M.D., Allegheny County Medical Society
Author: James A. Nicotero, M.D.

WHEREAS, The United States Supreme Court has held that " . . . if a physician is licensed by the State, he is recognized by the State as capable of exercising acceptable clinical judgement . . . " (Doe vs. Bolton, 410 U.S. 179) (1973); and

WHEREAS, The State Department of Health has recently embarked upon oppressive and entirely discriminatory regulations upon the ethical and moral practice of medicine, through regulatory interpretations of the Legislative Act of 1961; and

WHEREAS, The State Department of Health has arbitrarily and inappropriately placed all physicians in a single category as if there were no specialties in medicine; and

WHEREAS, Through these acts the State Department of Health now seeks to prevent the physician from exercising appropriate clinical judgement in the decision to perform a laboratory test upon a patient when the physician has the capability to perform such laboratory analyses in his own office pursuant to his specialty; and

WHEREAS, The efficiency, reproducibility and availability of laboratory testing within the physician's office is distinctly in the patient's advantage and should not be construed as being scurrilous before the fact; and

WHEREAS, It is repugnant to the practice of medicine, as it has been traditionally known, for a legislative body to force upon the practitioner prohibitions to the responsible practice of his specialty by limiting his ability to perform needed laboratory studies on his patients when his office is so equipped; therefore be it

RESOLVED, That the Pennsylvania Medical Society formally protest the reckless, provocative discriminatory, and entirely unwarranted regulatory barriers that are being placed in the way of responsible medical care in this Commonwealth by sharply limiting the ability of a health professional to determine what studies his patient needs, and to have the right to make those laboratory studies available to his patient in his office with a responsible staff and effective instrumentation; and be it further

RESOLVED, That the Pennsylvania Medical Society explore with all haste whether suit should be instituted against the Commonwealth of Pennsylvania on the grounds of its discriminatory posture in regard to the Laboratory Act and its interpretation, and question the constitutionality of such oppressive and arbitrary maneuvers.

The reference committee wishes to commend the Board of Trustees for its initiative in authorizing the filing of a suit against the proposed regulations if an equitable settlement cannot be effected by negotiation.

Mr. Speaker, your Reference Committee recommends approval of Resolution 75-30.

Supplemental Report G of the Board of Trustees (In Delegates' Packet)

The reference committee appreciated the detailed analysis of the practicality and the legality of the proposals. The reference committee heard no testimony in favor of "Screwing Up the System," and heard testimony only in the negative.

Mr. Speaker, your Reference Committee recommends that this item be filed.

Supplemental Report H of the Board of Trustees (In Delegates' Packet)

The reference committee noted that this poll was published in PENNSYLVANIA MEDICINE and was distributed to the members of the House. We heard no testimony challenging the validity of the poll.

Mr. Speaker, your Reference Committee recommends that this item be filed.

Supplemental Report I of the Board of Trustees (In Delegates' Packet) and Resolution 75-16: Malpractice Rating (In Delegates' Packet)

Since testimony indicated a feeling of inequity in the premium structure, there may be merit in seeking a more equitable means of distributing premiums in order to more accurately reflect claim costs.

Mr. Speaker, your Reference Committee recommends that Supplemental Report I of the Board of Trustees be filed.

(Secretary's Note: The House determined to refer Supplemental Report I back to the Commission on Professional Liability Insurance to correct inequities in the premium structure.)

Resolution No. 75-16

Subject: Malpractice Rating
Introduced by: Sidney A. Parsons, Jr., M.D., secretary, Delaware County Medical Society
Author: Sidney A. Parsons, Jr., M.D.

WHEREAS, The Counties of Delaware, Chester, Bucks, and Montgomery are grouped with Philadelphia County for Territory I Malpractice Rating by the Insurance Department, Commonwealth of Pennsylvania; and

WHEREAS, The Counties of Delaware, Chester, Bucks, and Montgomery are grouped with several other counties for Charge Class II payment for Medicare and Prevailing Fee Programs; and

WHEREAS, Only the Districts of Philadelphia and Pittsburgh are grouped as Charge Class I payment for Medicare and Prevailing Fees; therefore be it

RESOLVED, That the Pennsylvania Medical Society request the Insurance Commissioner, Commonwealth of Pennsylvania, be informed of this inequity and be urged to use appropriate means to correct the situation.

Mr. Speaker, your Reference Committee recommends referral of Resolution 75-16 to the Commission on Professional Liability Insurance.

Resolution No. 75-22

Subject: Expulsion of the Professional Expert Witness from the Pennsylvania Medical Society
Introduced by: Robert W. Allen, M.D., secretary, Mercer County Medical Society
Author: Robert W. Allen, M.D.

WHEREAS, The Pennsylvania Medical Society has expended much time and energy in trying to influence the State Legislature in malpractice reform; and

WHEREAS, H.B. 1367 does not define an expert witness; and

WHEREAS, The problem of the professional expert witness has been with us for many years but has not been openly confronted by organized medicine; and

WHEREAS, This is one of the few areas, if not the only one, where the House of Delegates can take a positive action in helping to correct the malpractice crisis independent of the State Legislature; therefore be it

RESOLVED, That testifying as an expert witness in a malpractice case outside of the specialty of the physician represents unethical conduct. In the future any physician who testifies as an expert witness outside of his specialty (or logical extension of their field of expertise) will be automatically expelled from the Pennsylvania Medical Society and this fact shall be publicized.

The reference committee heard a divergence of testimony on this resolution. Problems relating to the definition of an expert witness, the legality of the resolution, the problem of a conspiracy of silence and Justice Department sanctions were discussed. It was also pointed out that the resolution would have no impact on nonmembers and out-of-state witnesses.

Prolonged testimony within the reference committee in Executive Session, with input from the Judicial Council, brought out the very serious problems of the definitions of who is an expert witness, precluding outright approval of this resolution. Your reference committee is extremely sympathetic to this resolution, nonetheless.

Mr. Speaker, your Reference Committee recommends referral of this resolution to the Board of Trustees with the recommendation that the Board appoint a committee to study the problems posed by the question: "Who is an expert witness?"

(Secretary's Note: The House determined to adopt Resolution 75-22, with referral to the Committee on Constitution and Bylaws for preparation of any constitutional or bylaws changes necessary to implement the resolution. The author of the resolution accepted an editorial change, deleting the phrase "will be automatically suspended" and adding the phrase "will be subject to expulsion after due process."

Address of the President—New Rate Structure (In Delegates' Packet)

The reference committee heard testimony in favor of and no testimony against this proposal. The reference committee feels, however, that it is unlikely that until some data indicating a decrease in payout is established that insurance rates would go down.

Mr. Speaker, your Reference Committee recommends approval of this proposal.

Address of the President—Captive Company (In Delegates' Packet)

Testimony presented was in favor of contigency planning for a captive company, but reservations were expressed relating to our ability to do what the insurance companies have apparently not been able to do. The Activities of the Commission on Professional Liability Insurance would seem to fulfill the intent of Dr. Crane's recommendations and the reference committee believes that they should continue in that vein.

Mr. Speaker, your Reference Committeee recommends referral of this recommendation to the Commission on Professional Liability Insurance to continue in its work on this project.

Supplemental Report of Reference Committee on Medical Service A

Resolution No. 75-7

Subject: Prevailing Fee for Physicians
Introduced by: Conrad A. Etzel, M.D., delegate, Delaware County Medical Society
Author: Conrad A. Etzel, M.D.

WHEREAS, The malpractice premium rates in the four counties surrounding Philadelphia County are the same as Philadelphia County; and

WHEREAS, The Blue Shield premiums for the consumers are nearly the same for this geographical area; and

WHEREAS, The administrative and overhead expenses are nearly the same; therefore be it

RESOLVED, That the prevailing fee for physicians in these areas be raised immediately to those of Class I area of Philadelphia County.

Testimony on this resolution indicated to the reference committee that there may be a real inequity in rates for professional liability insurance. Testimony from Blue Shield representatives reviewed the fact that Prevailing Fee payments are based essentially on charges. It is not a fee schedule, but rather, it reflects physicians' actual charging patterns.

Mr. Speaker, your Reference Committee recommends that this resolution be referred to the Council on Medical Service for study.

Resolution No. 75-19

Subject: Blue Shield Fees
Introduced By: O. K. Stephenson, M.D., secretary, on behalf of the Perry County Medical Society
Author: O. K. Stephenson, M.D.

WHEREAS, Equal pay for equal work is a fundamental principle of equity; and

WHEREAS, The present Blue Shield fee schedule does not provide equal pay for equal work and is thus inequitable and discriminatory; therefore be it

RESOLVED, That the Pennsylvania Medical Society recommend to Pennsylvania Blue Shield the adoption of a uniform fee schedule throughout the state.

The reference committee considered that physicians have long desired third parties to pay for their services on the basis of actual charges. The Blue Shield Prevailing Fee Program is designed to do this. The wish of the membership in this regard clearly favors the Prevailing Fee concept.

Mr. Speaker, your Reference Committee recommends rejection of Resolution 75-19.

(Secretary's Note: The House turned down the recommendation of the reference committee and approved Resolution 75-19 with an amended resolve which reads: "RESOLVED, That the Pennsylvania Medical Society recommend the adoption of a uniform charge class for all prevailing fee plans throughout the state.")

Reference Committee Education and Science

Robert N. Moyers, M.D., chairman, presented the following report of the committee:

Your reference committee has grouped the following items together in a Waiver of Debate list. In each instance there was little or no testimony heard and the committee feels the items are of a noncontroversial nature.

Mr. Speaker, we recommend the following actions on each item:

Report of the Committee to Study Relations Between Medicine and Osteopathy *(Offical Reports Book*, page 60) (Approve)

Report of the Special Committee on Family Medicine *(Official Reports Book*, page 22) (Approve)

Report of the Educational and Scientific Trust (Delegates' Packet) (Approve)

Report of the Council on Education and Science *(Official Reports Book*, page 60)

This report is an excellent informational summary of the council's work. The position statement on marihuana on page 62 of the *Official Reports Book* was adopted by the Board of Trustees and Councilors at its August 13, 1975, meeting. Your reference committee accepted this as an informational item only.

The *RESOLVED* on page 65 of the *Official Reports Book* regarding the residency placement program which was recommended for adoption by the council certainly has merit. The dissemination of information to directors of medical education regarding the matter of physician services in the Commonwealth certainly is a systematic approach rather than the haphazard programs presently supported.

Your reference committee recommends that the Society undertake this project on a limited basis with the financial limits set by the Board of Trustees and Councilors in accordance with Society priorities.

Mr. Speaker, we recommend the adoption of this portion of the Reference Committee report.

Report of the Committee on Aid to Education *(Official Reports Book,* page 55)

This report is informational. We concur with the committee's urging that an allocation of $8 from the annual assessment to the educational fund be continued.

Mr. Speaker, we recommend the adoption of this portion of the Reference Committee report.

Report of the Committee on Relationships with Allied Professions *(Official Reports Book,* page 59)

Supplemental Report of the Committee on Relationships with Allied Professions (Delegates' Packet)

The supplemental report of this committee has indicated the need to establish working policies with the nursing profession. The report presented a proposed joint practice statement for comment by members of the House. If the nurse practitioner concept is to be developed to its fullest potential, guidance must be sought from the physician who is ultimately responsible for the medical care and treatment of the patient.

Mr. Speaker, your Reference Committee recommends rejection of the report and suggests that the committee be instructed to work out another statement that recognizes that the physician is responsible for directing patient care.

Resolution No. 75-2

Subject: Deletions of Sections 5, 6, and 7 of the Bylaws of the Pennsylvania Medical Society re Mandatory Continuing Education as a Prerequisite for Membership

Introduced by: Robert E. Gregory, M.D., James R. Dornenburg, M.D., Lyndon Landon, M.D., (Allegheny County), Arthur Patterson, M.D. (Greene County) and John Boal, M.D. (Beaver County)

Author: Robert E. Gregory, M.D.

WHEREAS, The physicians of Pennsylvania are totally aware of the need for education and the updating of medical knowledge on a personally planned program; and

WHEREAS, It has been well documented that mandated education does not insure an adequate education and most certainly does not insure adequate performance; and

WHEREAS, The present sections of the Bylaws have caused the creation of new university departments throughout the country, solely to compete for the educational dollar at great cost to the universities and even greater cost to the physician; and

WHEREAS, Certain of these programs offer only major escape mechanisms without any real educational concern by the involved physician; and

WHEREAS, Such mandation of education is arbitrary and capricious; and

WHEREAS, It places an undue burden on the physician who is not university affiliated, nor in reasonable proximity to such institutions; and

WHEREAS, The proposed mandatory program has presented serious legal difficulties and appears to establish new standards for judging the level of professional competence among physicians; and

WHEREAS, In this day of escalating insurance premiums and inflation, the cost of meeting these continuing educational requirements appears to be an unjustified financial burden; therefore be it

RESOLVED, That Section 5, Section 6 and Section 7 of the Bylaws of the Pennsylvania Medical Society be changed to eliminate the requirement of continuing education on a mandatory basis as a requirement of membership in the Pennsylvania Medical Society; and be it further

RESOLVED, That the Society continue to provide a continuing education program on a voluntary basis; and be it further

RESOLVED, That the Society encourage peer review and performance on a local hospital level as measured by one's patients and his peers.

Your reference committee heard arguments presented both pro and con regarding the present continuing medical education requirement. We believe that the positive aspects of this program far outweigh the adverse publicity that would result in removing a mandatory educational

policy and making it voluntary.

Your reference committee notes that there has been an ongoing revision of requirements and deadlines and we believe that before the Society abandons a mandatory educational requirement that these revisions should be implemented and their results evaluated.

Mr. Speaker, we recommend the rejection of Resolution No. 75-2.

(Secretary's Note: This resolution was considered at the meeting of the Report of the Reference Committee on Constitution and Bylaws and was rejected at that time.)

Resolution No. 75-21

Subject: Legislative Action Requiring Documented Medical Evidence For the Performance of Abortion

Introduced by: John D. Lane, M.D., delegate, Bucks County Medical Society

Author: John D. Lane, M.D.

WHEREAS, The United States Supreme Court stated it was not allowing abortion on demand; and

WHEREAS, The United States Supreme Court stated expressively that abortion was the decision of the woman and her physician, not that of the woman alone; and

WHEREAS, The Pennsylvania Medical Society has recommended documented medical evidence for the performance of an abortion; therefore be it

RESOLVED, That the Pennsylvania Medical Society initiate and support legislative action requiring documented medical evidence for the performance of an abortion; and be it further

RESOLVED, That the Pennsylvania Delegation to the House of Delegates of the American Medical Association be instructed to introduce and support a similar resolution at the next meeting of that body.

Your reference committee has determined that our present policy on abortion is an ethical position and there is no need to update it or to codify our position through the law.

Mr. Speaker, we recommend the rejection of Resolution No. 75-21.

Resolution No. 75-3

Subject: Abortions

Introduced by: Edward J. Resnick, M.D., secretary, on behalf of the Philadelphia County Medical Society

WHEREAS, The stated position on the subject of abortion by the Pennsylvania State Medical Society antedates the 1973 United States Supreme Court ruling on the matter and is in direct conflict with it and with the current interpretations of our own Pennsylvania State Medical Society legal counsel; and

WHEREAS, The Department of Public Welfare of the Commonwealth of Pennsylvania is specifically using this outdated and contralegal position as the basis for refusing to pay for legal abortions for the underprivileged patients on Medicaid; and

WHEREAS, The hospitals (and physicians) in this Commonwealth have accrued a tremendous backlog of unpaid but justified fees due for care of these underprivileged patients; therefore be it

RESOLVED, That the Pennsylvania Medical Society review its policy statement on abortion to update it and bring it into line with the law of the land.

The WHEREASES of Resolution No. 75-3 addressed themselves to payment mechanisms, which is an issue between the Commonwealth of Pennsylvania and the decision of the Supreme Court. We offer the following substitute resolution:

RESOLVED, That the Pennsylvania Medical Society request the Pennsylvania Attorney General to render a formal clarifying opinion on the relationship between the United States Supreme Court decision and the current Pennsylvania statute on abortion and further clarify the obligations of the Pennsylvania Department of Public Welfare as they relate to those statutes and payment for the provision of abortion services.

Mr. Speaker, we recommend the adoption of the substitute resolution.

Resolution No. 75-8

Subject: Criticism of a Colleague to a Patient to be Avoided

Introduced by: L. Marvin Clark, M.D., delegate, from Clarion County

Author: L. Marvin Clark, M.D.

WHEREAS, Criticism of a colleague to his patient is detrimental to the patient because it lowers the patient's confidence in the medical profession; it is detrimental to the medical profession in general; it may cause the criticized physician some unnecessary and undeserved harm, and harms the critic's reputation; and

WHEREAS, Such criticism may be another factor contributing to the increased number of malpractice suits; and

WHEREAS, Such criticism is not a constructive way of dealing with situations involving alleged wrongful care of a patient by a colleague; and

WHEREAS, Both the American Medical Association and the Pennsylvania Medical Society Code of Ethics reject such criticism (AMA Principles of Medical Ethics, Section 1, Paragraph 10); therefore be it

RESOLVED, That the Pennsylvania Medical Society reaffirm its rejection of such criticism of a colleague stated to a patient; and be it further

RESOLVED, That an educational program be developed by the Pennsylvania Medical Society, with the possible cosponsorship of the American Medical Association and/or a malpractice insurer to instruct physicians and their assistants to avoid such criticism and to instruct them in constructive ways of seeking solutions to the problem of alleged wrongful care of a patient by a colleague.

Your reference committee agrees with the first *RESOLVED* but recommends the substitution of a second *RESOLVED* because of an undeterminable financial im-

pact or effectiveness of such an educational program. The following is the substitute *RESOLVED:*

RESOLVED, That the Council on Professional Relations and Services consider during the coming year the cost benefits of developing a program of instruction to members regarding ethics. Unless such a program appears worthwhile, we recommend that these principles be brought to the attention of Pennsylvania physicians through the Society's usual channels of communication.

Mr. Speaker, we recommend the adoption of the amended resolution.

Resolution No. 75-14

Subject: "Energy Parks"

Introduced by: John Cavender, M.D., Susquehanna County, and Sidney O. Krasnoff, M.D., Philadelphia County

Author: Sidney O. Krasnoff, M.D.

WHEREAS, The citizens of several rural low density populated areas in this Commonwealth have suddenly been exposed to plans for the construction of "Energy Parks;" and

WHEREAS, The construction and operation of these plants will create major environmental as well as public health problems heretofore not present in these areas; and

WHEREAS, The potential for nuclear accidents and devastating effects always exists despite claims to the contrary; therefore be it

RESOLVED, That the Pennsylvania Medical Society be on record as opposing the creation of "Energy Parks" as presently conceived; and be it further

RESOLVED, That this resolution be forwarded to the Governor of the Commonwealth, United States Senators and Representatives and that members of the Pennsylvania Medical Society be urged to inform the State and Federal legislators of their concern.

Your reference committee is of the opinion that it will be necessary in the future for energy sources to be built to sustain our way of life. For a responsible organization of physicians to make such a pronouncement at this time regarding the operation of energy parks seems premature. Information we've received from the Governor's Energy Council has stated that all aspects of energy parks have not been sufficiently evaluated to determine whether or not they should be supported or opposed. Until knowledgeable bodies competent to analyze the technical data associated with the proposed energy parks have reviewed this material and made definitive decisions, we believe this resolution to be premature and would recommend its rejection. However, we do believe that the Council on Education and Science should continue to monitor the future development of energy parks.

Mr. Speaker, we recommend the rejection of Resolution No. 75-14.

(Secretary's Note: Resolution 75-14 was rejected, and the House adopted a substitute resolved which reads: "RESOLVED, That the Council on Education and Science closely monitor the development of energy parks in the Commonwealth of Pennsylvania.")

Resolution No. 75-24

Subject: Regionalization of the Activities of the Joint Commission on Accreditation

Introduced by: Joseph V. Caliguiri, M.D., secretary, on behalf of the Allegheny County Medical Society

Author: Matthew Marshall, Jr., M.D.

WHEREAS, The American Medical Association is charged with developing a plan with the assistance of the Joint Commission on Accreditation of Hospitals, by which the function of the Joint Commission on Accreditation can be carried out without duplication at the state or regional level with the assurance that those aspects of accreditation relating to physician care will be evaluated by physicians, utilizing their own voluntary format for the surveys; and

WHEREAS, State medical associations are encouraged to cooperate in this endeavor; and

WHEREAS, A progress report will be submitted to the AMA in 1975 at the Clinical Convention; therefore be it

RESOLVED, That the Pennsylvania Medical Society take an active role in the decentralization of JCAH activities and in the development and implementation of this plan in conjunction with the American Medical Association.

Your reference committee heard no testimony supporting this resolution but we believe that our Society should take an active part in the decentralization of JCAH activities in regard to Pennsylvania.

Mr. Speaker, we recommend the adoption of Resolution No. 75-24.

Distinguished Guests

The following distinguished guests were presented to the House: Dr. Harold F. White, president, Pennsylvania Osteopathic Medical Association; Dr. Calvin B. Hearne, president of the Medical Society of Delaware.

Reference Committee Professional Relations and Services

Henry H. Fetterman, M.D., chairman, presented the report of the reference committee.

Item No. 1—Report of the Council on Professional Relations and Services *(Official Reports Book,* page 77)

Supplemental Report, Council on Professional Relations and Services (Contained in the Delegates' Packets)

Because of the similar nature of the two reports, the reference committee considered them as one item.

The council's report is very informative. It was reviewed

and found to be detailed and impressive. The Reference Committee would like to make special note of the formation of the Pennsylvania Medical Cooperative in 1975. Much time and effort was spent not only by council members but also by dedicated staff in the developmental stages of this project. The reference committee commends the council and its staff for the development of this unique, first-of-its-kind mass purchasing organization for physicians.

Mr. Speaker, the Reference Committee recommends that the report be filed.

The reference committee reviewed that portion of the supplemental report recommending the extension of the moratorium on delinquent dues for one additional year in order to return to membership those physicians who were dropped in recent years for non-payment of dues.

Mr. Speaker, the Reference Committee recommends that the moratorium on delinquent dues be continued for one additional year.

The reference committee also reviewed a proposal for a provisional membership category which was also mentioned in the council's annual report and concurs with the recommendation that the entire procedure for membership entrance into the Society be reviewed by the Council on Professional Relations and Services with the intent of simplifying the process.

Mr. Speaker, the Reference Committee recommends that a proposal for a provisional membership be referred back to the Council on Professional Relations and Services for further development.

Item #2—Waiver of Debate List

The reference committee has grouped the following items together in a waiver of debate list.

Report, Advisory Committee to the Woman's Auxiliary (Page 55) Filed

Address of the President, PMS Woman's Auxiliary, Filed

Report, Committee on Medical Benevolence (Page 58) Filed

Supplemental Report B, Board of Trustees and Councilors (Page 83) Approved.

Resolution 75-11—AMA Membership (page 94) Approved

The committee feels that the items are of a noncontroversial nature. The committee commends Mrs. Grandon for her year of leadership and her excellent talk, Mrs. Wilkinson for her outstanding remarks, and the entire Woman's Auxiliary for their support throughout the years.

Mr. Speaker, the Reference Committee recommends the following:

File Report, Advisory Committtee to the Woman's Auxiliary.

File Address of the President, PMS Woman's Auxiliary.

File Report, Committee on Medical Benevolence.

Approve Supplemental Report B, Board of Trustees and Councilors.

Approve Resolution 75-11—AMA Membership.

Item #3—Report, Committee on Medicine, Religion and Bioethics (Page 59)

The reference committee feels that this committee has an admirable goal in the difficult area of bioethics, but feels it is not necessary to expand the membership from 13 to 20 to obtain the expertise in this area. Rather than expanding the number of the committee, the reference committee feels that new appointments should be made on the individual's expertise in bioethics.

Mr. Speaker, the Reference Committee recommends that the recommendation contained in the report of the Committee on Medicine, Religion and Bioethics not be adopted.

Resolution No. 75-10

Subject: Public Awareness and Education

Introduced by: Howard L. Carbaugh, M.D., secretary, on behalf of the Lehigh County Medical Society

Author: Robert M. Jaeger, M.D.

WHEREAS, Medical programs viewed by the public on the major television networks, e.g., Medical Center, Marcus Welby, M.D., etc., may be somewhat entertaining; and

WHEREAS, In this time of Medico-Legal encounters which can arise from many of the types of procedures which are portrayed by these programs; and

WHEREAS, The citizens of the United States should be made aware of the many possible negative aspects relative to such procedures; therefore be it

RESOLVED, That the American Medical Association educationally rebut all TV medical shows by soliciting five minutes of descriptive time or preferably by appealing to the emotional consumer goodwill of the producers and the Federal Communications Commission for the public good; and be it further

RESOLVED, That this resolution be forwarded to the American Medical Association House of Delegates for action at their next session in December, in Honolulu, Hawaii.

The reference committee is in sympathy with the resolution but feels that from a practical standpoint, it is doubtful that the American Medical Association can influence significantly the content of medical shows produced for entertainment. However, it is the opinion of the reference committee that some effort should be made to make the citizens of the U.S. aware of the distortion of fact presented in some shows. Therefore, an amended resolution is recommended.

RESOLVED, That the citizens of the United States

should be made aware of the many positive aspects of good medical practice; and be it further

RESOLVED, That the American Medical Association increase its efforts to influence not only the medical accuracy of the medical shows but also their content and positive impact on the viewers; and be it further

RESOLVED, That the resolution be forwarded to the American Medical Association House of Delegates for action at the December Clinical Session in Honolulu, Hawaii.

Mr. Speaker, the Reference Committee recommends that the amended resolution be approved.

Delegate Badges

Dr. Witt called the attention of the House to the success of last year's efforts to recycle delegates' badges. He pointed out that a box at the rear of the room had been provided in which delegates should drop their badges as they leave.

Commendation of Ad Hoc Committee

A motion was offered from the floor commending the Ad Hoc Committee on Malpractice Insurance, the Auxiliary to the Pennsylvania Medical Society, and the Society staff for their efforts in promoting the legislative solution to the professional liability insurance crisis. The motion was approved by acclamation.

Annual Assessment

Ralph K. Shields, M.D., chairman of the Finance Committee of the Board of Trustees and Councilors, presented the following report containing the recommendation of the Finance Committee that the annual assessment for full dues paying members for 1975 be $150.

Mr. Speaker, members of the House of Delegates, the Board of Trustees recommends that the 1976 annual assessment for active members of the Pennsylvania Medical Society be $150.

Contingent upon the approval by the House of the 1976 assessment, the Finance Committee plans to introduce a resolution before the Board of Trustees which will recommend that 5.33 percent of the annual assessment be allocated to the Educational Fund of the Educational and Scientific Trust of the Pennsylvania Medical Society, which in the case of full dues paying members will amount to $8.00.

The Finance Committee also plans to recommend to the Board of Trustees that of the annual assessment paid by each active dues paying member, 1.33 percent, or $2.00 in the case of full dues paying members, be allocated to the Medical Benevolence Fund.

This means that $140 of the annual assessment of each full dues paying member will be available to the General Fund for operating expenses of the Society.

New Business

Motion: It was moved and seconded that the speaker and vice speaker be congratulated on the way in which they conducted the meeting. Motion carried by acclamation. The House of Delegates adjourned at 11:45 a.m.

Respectfully submitted,
John B. Lovette, M.D., Speaker
D. Ernest Witt, M.D., Vice Speaker
G. Winfield Yarnall, M.D., Secretary
John C. Rogalski, Assistant Secretary

Appendices

Appendix A

1975 Annual Report of the Pennsylvania Medical Political Action Committee

Mr. Speaker, members of the House of Delegates, and guests, it is my sincere privilege to present the annual report of the Pennsylvania Medical Political Action Committee.

Reporting chronologically, to bring you up to the present—as you will recall, one month after the adjournment of this House, in October of 1974, there was election day—November 5th. Your PaMPAC organization backed 99 legislative candidates in that election. Eighteen lost, but 81 won, for a percentage record of 81.8. To once again show each of you that PaMPAC is more concerned with the abilities and philosophy of the candidate than in affiliation with a political party, here is the summary: In the Congressional races, 9 Democrats were supported, with 8 winning and 1 losing; 10 Republicans were supported with 8 winning and 2 losing. In the Pennsylvania State Senate, 6 Democrats were supported with 6 winning; 3 Republicans were supported with 1 winning and 2 losing. In the State House Race, 18 Democrats were supported with 18 winning. Fifty-three Republicans were supported with 40 winning and 13 losing. In these races, PaMPAC put in $81,000 of your contributed dues.

On the national scene, the American Medical Political Action Committee, or AMPAC, contributed nearly $1 million to 270 national candidates for Congress. The record shows winners in 14 of 22 Senate contests and 183 winners in 248 House races; 98 percent of that AMPAC money came from the state PACs in the form of a $10 contribution per member. You should be interested to know that over $50 million was spent on the Congressional campaigns, $10 million coming from special interest groups. Who were they? Organized labor provided $4.3 million; organized health groups, $1.6 million; and business groups $1.7 million. The rest was composed of agricultural, educational, and ideological groups.

From time to time our PaMPAC office has been asked by

our membership to publish a list of those candidates who have received PaMPAC financial support. None of the organized political action committees publish such a list for several reasons. First, it could become a weapon in the hands of those not supported. Second, it is the candidate's prerogative to decide when and how to acknowledge financial support in the campaign. The list of candidates supported is a matter of public record with the Senate and House Supervisory Offices. PaMPAC has always complied with all Federal and State reporting requirements. Be assured that there is no attempt to withhold specific information from individuals who have a need to know. If you desire to know some specific information about your local situation, contact your PaMPAC board member.

In January of this year, the trustees of the Pennsylvania Medical Society appointed five new directors to the PaMPAC board and renominated seven continuing directors to a one year term. The new directors who represent you in the same geographical distribution as Councilor Districts are: Paul Kase, M.D., from Harrisburg, for the Fifth District; Preston Hoyle, M.D., of Lewisburg, for the Seventh District; Anthony Merski, M.D., from Erie, for the Eighth District; Robert Goldstrohm, M.D., from Indiana, for the Ninth District, and Michael Levis, M.D., from Pittsburgh, for the Tenth District.

Renominated directors include Philip Ingaglio, M.D., of Philadelphia, for the First District; myself, from Reading, for the Second District; Charles Zug, M.D., of Bethlehem, for the Fifth District; David Scicchitano, M.D., of Mt. Carmel, for the Fourth District; Joseph Stowell, M.D., of Altoona, for the Sixth District; John Lovette, M.D. of Johnstown, for the Eleventh District, and Charles Kraft, M.D., of Meshoppen, for the Twelfth District.

At the first meeting of this newly appointed board in February, four board members-at-large were elected. These include James Dunn, M.D., of Drexel Hill, for his fifth term, while John Robertson, M.D., of Philadelphia, Theodore Nelson, M.D., of Pittsburgh, and Joseph Silverman, M.D., of Altoona, were elected to serve their first terms. All these doctors are your representatives to the PaMPAC board and are there to serve you. Please use them!

This newly constituted board of directors took several important steps. Membership became the item of first priority. Each off election year, membership drops, and this year was no exception. The early count showed a loss of approximately 600 members from the roll. The board therefore voted to make each director responsible for recruitment of non-PAC members in his respective councilor district. Letters were sent out over the signature of either the PaMPAC director or the local county president. Editorials supporting PaMPAC appeared in county bulletins. This campaign has recruited approximately four hundred members.

A successful program to urge sustaining membership has been achieved. As you recall, a sustaining member contributes $100 a year. In 1973 there were four sustaining memberships in PaMPAC. In 1974, that had increased to nineteen, while today it is fifty-two. The board of PaMPAC passed Bylaws changes requiring sustaining memberships for directors, while the PMS board unanimously supported the principle of sustaining membership for itself and for the councils.

These gains are encouraging, but ever so small for the time, energy, and money spent. Instead of four hundred, there should be four thousand new members. You should know that there are still five counties that have not included the PaMPAC volunteer contribution on their county billing. This form of billing has proven to be the most effective method of gaining active members. Exclusion of PaMPAC in certain counties weakens the PAC and the political effectiveness of the Pennsylvania Medical Society.

Historically, PaMPAC has backed only candidates for national and state legislative positions because this was the level at which laws affecting medicine originated. Such is no longer entirely true, since new laws give local authority to county and city officials. Therefore, I am sure you will understand our problem in trying to cover increasing areas of demand with the dollars made available from a decreasing membership.

What do we, the PaMPAC board, suggest to correct this problem? We believe—and we know—that answer is you. We want not only your money but your personal involvement. If you don't know how to get involved, we will run a workshop in the spring to show you how to roll up your sleeves and get involved in political campaigns.

Last year I quoted to you that "The physicians truly concerned about patient care will get involved in the legislative and political area so that they will have a voice in matters directly affecting patient care." That philosophy has been tested this year in our efforts to get good malpractice legislation. It takes a team consisting of knowledgeable leaders backed by an aggressive, concerned membership at the grass roots. Those people such as the H-805 Committee physicians and their wives, can really make the difference. Now that we have shown our muscle on an issue, politicians are interested in tapping some of the same energy for their campaigns.

Each of us who has been involved in the workings of the Council on Governmental Relations and the Pennsylvania Medical Political Action Committee has been able to see first hand the effect of years of well-earned respect and trust given to our lobbyists by the legislators, the meticulous preparation and obvious sincerity in those testifying for the Pennsylvania Medical Society, and the enormous skill of our legal consultants in carrying out proposals for better legislation in the halls of the House and Senate. It has been a great source of pride for me to observe what has been done for you and the people of this state by your Society.

As the retiring chairman of this political committee, I ask of you only one commitment. If you believe that the Pennsylvania Medical Society is the organization that should represent you in the federation of physicians in this great state and country, then believe also that, without a well financed functioning political action committee, that same Pennsylvania Medical Society will be much less an effective political force. Please do not impair this symbiotic relationship by withholding support from one partner. As a member of PMS, enthusiastically join the volunteer organization that does so much for you—the Pennsyl-

vania Medical Political Action Committee.

Mr. Speaker, I thank you and this House of Delegates for your responsible leadership and continuing support.

Appendix B

Address
A. Reynolds Crane, M.D., President

Once again I would first pay tribute to this House, to the Councils and Commissions, to the Woman's Auxiliary and to the administrative staff for the work and accomplishments of the past year which are well described in your *Official Reports Book*. Reading it is reassuring and encouraging and may assuage some of your frustrations.

There are but two subjects that I will speak on today—malpractice and regimentation—for they are of the greatest import to our patients and to our ability to care for those patients. I could stand up here, take credit for the malpractice bill which is about to be passed and tell you, as some will, that your efforts are crowned with success and the bill about to be enacted will significantly alter the malpractice atmosphere—but that would be deceitful for nothing is further from the truth.

The fact remains that in every forum across the country it is recognized that meaningful reform rests upon application of reasonable limits to awards, binding arbitration, containment of contingency fees and modification of the tort system as proposed in H.B. 805. None of these are present in H.B. 1367 as amended by the Senate and which probably will be passed and signed into law, regardless of our position on it, when the Legislature reconvenes next week. It guarantees a source of payments for awards but does nothing to correct the abuses of the system. It is a poor excuse for a corrective measure but the prevailing sentiment, I fear more of fatigue than conviction, runs, "It is not what we wanted, but we can live with it," or "It is the best we can get." In a sense, each of these is true for it is a bill evolved to legalize and perpetuate the present system with as little modification as possible. The only beneficiaries are members of the Bar.

Jeffrey O'Connell, distinguished professor of law and father of the no-fault automobile insurance concept, put it well: "We lawyers have devised a legal insurance mechanism for dealing with adverse results from medical care that is just about the worst system imaginable, a system not devoted to paying people injured in the course of treatment where feasible, but a system devoted to fighting people about paying them from a health care provider's insurance. The Indiana statute—except for easing the threat to insureds and insurers of very large verdicts—does little or nothing to lessen the need for expensive, extensive negotiation and adjudication over responsibility for adverse medical results. . ."

That is where we are. When we started we expected to be frustrated, thwarted, circumvented and balked and that we would have to go back again and again over years to obtain meaningful reform. That situation you now face in reality. Although the comments made in my letter of August 7 still pertain, let me review for you various features of this legislation and make some recommendations for your continued action as I relinquish the reins.

H.B. 1367

I. The Insurance Provision of the bill has three portions:

(a) A mandatory requirement that each physician (or health care provider) carry $100,000/300,000 of insurance (701a) and that the liability of any *carrier (not the provider)* is limited to that amount (701b).

(b) A contingency loss (701c, d, e) fund of $15 million to be raised by a surcharge of up to 10 percent of the premiums of each provider (M.D.; D.O.; D.S.C.; hospital; nursing home; HMO—dentists are not mentioned). The fund is to be run by a director appointed by the Governor (702). Awards in excess of $100,000/300,000 will be paid from this fund but the limit for one provider shall be $1/3 million. If this fund is exhausted in one year, awards are to be prorated against succeeding years. The fund is also liable for the deficit of the JUA and for claims made four or more years after an incident. If this fund falls below $7.5 million and the Assembly does not act to correct it within twenty-five days, the fund will cease to exist.

(c) A JUA is established (VIII) to cover providers unable to obtain insurance at rates "not in excess of those applicable to similar health care providers." If 50 percent of providers in classes 3, 4, or 5 cannot obtain coverage in the general market, the JUA will become exclusive and be the only form and source of malpractice insurance.

What this section means to you is:

(1) Your premium for $100,000/300,000 will be:

		Medical Protective	*Argonaut*
Zone I	Class 1.	800 ±	1,100 ±
	5.	8,000 ±	18,000 ±
Zone II	Class 1.	650 ±	950 ±
	5.	4,500 ±	9,000 ±

(2) You will be covered for $100,000/300,000 by your carrier and for $1/3 million by the fund. The carrying of an umbrella by you over the $1/3 million will only encourage larger claims.

(3) A reduction in the premium is not likely for increased costs of processing claims through the arbitration panel and the probability of increased claims may offset the savings from any reductions required in reserves.

(4) Insurance will be available for everyone but the rates will remain excessive.

(5) The continued solvency of the contingency loss fund is questionable, particularly when one remembers the old adage, "If you have money, there is always someone standing by to take it away from you."

(6) The coverages of $100,000/300,000 and $1/3 million will be common knowledge and encourage higher awards.

(7) This section is the only potential physician benefit in the bill. Certainly the man faced with a $9,000 or $18,000 premium still has a major problem and some will be forced to discontinue their specialty.

Recommendation: Because of the relief given to carriers through the reduction of liability and elimination of the tail, it is proper that the rate structure now be reexamined. I, therefore, recommend that immediately on passage of 1367 the Pennsylvania Medical Society ask the Insurance Commissioner to require new filings from all carriers and that new rates be established now in light of the legislation.

II. Arbitration

A compulsory but not binding arbitration system is established (308) to be run by an administrator appointed by the Governor within the Department of Justice. The panel will consist of two providers, two lawyers, one of whom is chairman, and three laymen. A new panel is to serve for each claim. The panelists are appointed by the administrator who must first attempt to obtain concurrence of the litigants by giving them lists of panelists to choose from. Decisions of the panel may be taken to court but the decision and facts, if any, may be introduced into the proceedings. Contained in this plan is a requirement that PSRO norms, standards and criteria be made available to all parties (508-a-5).

Comment: Of all the panel plans suggested this is the worst, being cumbersome, costly and unsatisfactory—in effect being a pre-jury jury trial. You should note that the panel (three laymen, two lawyers and two providers) decides all matters, except of law, by majority vote. In other words one lawyer dictates the law but no physician may decide the validity of any medical aspect of the case. What a travesty! Incorporation of the PSRO data was at the insistence of the trial lawyers in the House. This is a use for which the criteria were not developed and their application to malpractice litigation can only lead to false incriminations.

Recommendation: I recommend that the matters of panel composition be referred to a special reference committee to assess the concerns here expressed and to consider the feasibility and advisability of a program of nonparticipation.

I further recommend that the Pennsylvania Medical Society introduce legislation to interdict the application of PSRO data to the assessment of medical practice in litigated cases and that until such time as that change is made, the PSRO activities and development be held in abeyance and HEW so notified.

III. Punitive Damages

These may be assessed (603) for willful or wanton misconduct.

Comment: Punitive damages really constitute a fine and as such belong to the state, not a litigant or a lawyer. They are used and promulgated as a means of increasing awards above actual losses incurred and to increase the lawyer's "take."

Recommendation: I recommend that the Pennsylvania Medical Society introduce legislation which will call for the payment of any and all awards for punitive damages to the state and prohibit collection of a contingency fee on such punitive damages.

IV. Contingency Fee

The contingency fee (604a) is legalized at 30 percent, 25 percent, and 20 percent for the first, second, third and every succeeding $100,000.

Comment: These fees may be in addition to expenses. I see no way of altering this extortion which encourages suits and the seeking of unreasonable awards. Some of your colleagues say we should not tamper with legal fees if we do not want ours governed. The day is long since past when you set your own fees. Try looking at the SSA, Medicare, Medicaid, etc., to see who does set your fees.

V. Pain and Suffering

The concept of payment for pain and suffering is not mentioned in the bill and remains the big bonanza. We all endorse retribution for actual losses incurred, including loss of income within reason, but not so unreasoned and unmeasurable an item as pain and suffering.

Recommendation: I recommend that this Society seek means of eliminating or restricting the application of the concept of pain and suffering and that legislation be considered to prohibit the application of a contingency fee to awards for pain and suffering.

I have taken the time for this brief review, believing that we do not have time to "wait and see" what happens, but rather, that diligent pursuit of corrective legislation must be continued in finite detail. I do so in the belief that you are not of a mind to take what you have been given, nor to pack your little black bag, nor to tuck your tail between your legs, nor to go out the door and await the next assault on your efforts to care for the sick.

We have sent a letter to the Governor, to the leadership of the Senate and the House and I would like to read it to you: "My Dear Governor: House Bill 1367 - the malpractice bill - was not designed by the Pennsylvania Medical Society. It does not represent the position of organized medicine. It offers no real, long-term answers to the crisis in health care. The final version goes significantly beyond concessions to which the Society reluctantly acquiesced in order to get some short-range relief in a major emergency.

We recognize that the General Assembly and the Administration have searched assiduously for a solution. We thank those who have tried to help; but we don't believe they have found the answer. No legislative proposal will work that doesn't provide for a reasonable limit on outrageous, sky-high awards—and doesn't establish final, binding arbitration.

Organized medicine will keep on working for the adoption of a meaningful, long-term solution to the continuing crisis. Our job has just begun.

I recommend to this House that the House send a similar letter directly to the Governor and the presiding officers of the House and Senate.

Patient Contract

The concept that arrangements between a physician and his patient do constitute a contract that can be reduced to writing is still viable. With the morass produced by H.B. 1367, the development of the contract approach is

of increasing importance. Unfortunately, it too becomes quickly mired in the muck of legal technicality. I urge the continued assiduous pursuit of a satisfactory contract form with HAP and regret that I do not have one to offer at this time. However, since the ground has been laid and the concept developed, I hope and expect that a working version will be in your hands early in Dr. Masland's tenure.

Self Insurance

The development of our own insurance company promises not only possible savings but also the best means of knowing the details of malpractice coverage—actual operating costs, number of claims, number and amount of settlements, number and amount of awards. The Commission on Professional Liability under Dr. Joseph Danyo has been exploring the matter.

Recommendation: I recommend that a special committee now be designated to complete the detail of the organization, structure, and operation of such a captive company and would suggest that since Dr. Danyo's term on the commission is due to expire, he might be asked to complete the work he started.

Rules and Regulations

The bind of governmental rule and regulation at all levels is becoming increasingly restrictive. Those of you who are active in oncology are aware of the interdiction of the performance of assay for CEA by the Bureau of Laboratories and the Department of Health in Pennsylvania, an action which has put this state and that department up to ridicule across the nation. This is now followed by rules and regulations restricting the laboratory procedures you may do in your office—you may use dypsticks on urine but may not do a specific gravity. You may do an r.b.c. or w.b.c. but not a hemoglobin, hematocrit, or differential; you may look at stools for pin worms but not ova or parasites. We have forcefully objected to the promulgation of such rules and regulations and to the unauthorized extension of the Laboratory Act to physicians' offices and will pursue the matter in the courts if necessary. I mention this not so much in criticism but rather as an example of the problem of bureaucratic regulation before us on a broad front.

The thrust of CHP, Certificate of Need legislation, HMO, U-R, PSRO all produce an endless stream of rules and regimentation burying the basic purpose under a mound of the impractical.

Forbes Magazine predicts that medicine will become the first federally regulated profession because of its monopoly over health services and the cost of these services which is now 10 percent of the GNP. The splitting wedge is PSRO and HMO. Their conclusion is interesting: "The day of the rugged individual in medicine is fading. The change won't be an unmitigated disaster for the doctors. Nor will it be all gravy for the consumers since regulation means bureaucracy. This is the way things are going and the doctor of the future, while just as prosperous, will be less a free agent than he was."

You will recognize that everything I have put before you today is real—is too real—and is rule and regulation. How do you as an individual expect to cope—how do we as a group expect to cope? Will we cope or will we pack our bags and tuck our tails and accept what comes?

One year ago I urged unity to you through single county, state, and AMA membership. Now more than ever we need that unity and **I again recommend that this Society require AMA membership of all of its members that we may better cope with the increasingly dangerous restrictions placed upon the practice of medicine by an unresponsive and obsolescent legal system and a burgeoning bureaucracy.** It is becoming increasingly important that we have not only the strength of unity but the strength of solidarity. I no longer doubt that in the near future medicine will be unionized, not in the sense of strikes and violence, but in the sense of a guild with a strongly supported central voice as our only hope if we are to maintain the high standards we have set for ourselves and this country in the care of the sick.

It is time to consider the tools recommended to you at the special session of July 2-3, 1975, not for application now but for future use. It is time to take a careful look at collaborative collective effort and to use those aspects which will permit this Society to become the voice of medicine for the physicians of Pennsylvania since the Pennsylvania Medical Society is the only bond between the physicians of this state, regardless of specialty. Your Board has been asked and has agreed to establish a committee for this purpose, and **I now recommend that that committee be made a joint committee of the House and Board and that it be activated and funded herewith.** As of October 6, 1975, the charge best given to you is that of Chancellor Wallis of the University of Rochester, ". . .The lawyers have you outnumbered but on the average they are no match for you in intelligence, industry or dedication. Just don't let them ambush you while you are absorbed in caring for the sick."

Gentlemen, I am indebted to you for an intriguing year and one which none of us will soon forget and one which for me has, from blood sweat and tears, produced the closest friendships I have known. You are fortunate indeed in your new president as is he, first for having survived this year and as you will see with all the mix of composure, dedication, and conviction so essential to the days ahead. To him and you, God speed.

REFERRALS

1. Recommendation regarding new filings from all malpractice insurance carriers (top of page 3) referred to Medical Service A.
2. Recommendation regarding composition of the arbitration panels (page 3) referred to Governmental Relations.
3. Recommendation regarding interdiction of the application of PSRO data (page 3) referred to Medical Service B.
4. Recommendation regarding payment of punitive damages to the state (page 3) referred to Governmental Relations.

5. Recommendation regarding elimination of contingency fee to pain and suffering (page 4) referred to Governmental Relations.
6. Recommendation regarding development of captive insurance company (page 4) referred to Medical Service A.
7. Recommendation regarding unified AMA membership (page 5) referred to Constitution and Bylaws.
8. Recommendation regarding joint committee of House and Board (page 5) referred to Medical Service A.

Appendix C

Supplemental Report A
Board of Trustees and Councilors

(Referred to Reference Committee on Reports of Officers)

Last year the House of Delegates asked that the 1977 Annual Business Session site be changed from Pittsburgh to Lancaster. In March, the Board approved the dates Tuesday, October 25, to Thursday, October 27, 1977. The session will be held at the Host Farm Resort Motel in Lancaster.

The 1973 House of Delegates directed the Board to study the advisability of holding all annual sessions after 1978 in the Harrisburg-Lancaster area. At its August 1975 meeting, the Board decided to set the 1979 and 1980 sessions at the Penn Harris Motor Inn in Camp Hill, across from Society headquarters, since a cost saving would result from using headquarters facilities. The Penn Harris Motor Inn gave the Society excellent service during the Special Session of the House July 2 and 3, 1975.

Therefore, we recommend that the 1979 Annual Business Session be held at the Penn Harris Motor Inn from Thursday, October 11, to Saturday, October 13, and that the 1980 Annual Business Session be held at the Penn Harris Motor Inn from Thursday, October 9, to Saturday, October 11.

Appendix D

Supplemental Report B
Board of Trustees and Councilors

(Referred to Reference Committee on Professional Relations and Services)

At its August 1975 meeting, the Society's Committee on Quackery expressed its concern over the dissolution of the AMA's Committee on Quackery since the AMA's committee was the only national anti-quackery institution in this country.

The committee feels that every effort should be made to restore the committee and recommended to the Board that the resolution printed below be forwarded to the Society's delegates to the AMA with instructions that it be submitted for consideration at the 1975 AMA Clinical Convention.

The Board of Trustees approved the resolution but felt that it should be sent to the Society's House of Delegates for concurrence since the approval of the House, if granted, would give more support to the resolution in the AMA House.

Therefore, we recommend that the House of Delegates approve the following resolution for introduction at the 1975 AMA Clinical Convention:

WHEREAS, Physicians have a duty to protect the public from deceptive health practices and health misinformation; and

WHEREAS, The Society is active on the state level in combatting health fraud; and

WHEREAS, The State Society's Committee on Quackery cannot deal with quackery activity on a national level; therefore be it

RESOLVED, That the AMA be requested to restore its Committee on Quackery as a national coordinating body, and that the scope of activities of this committee include all health fraud and quackery rather than being confined to chiropractic.

Appendix E

Supplemental Report C
Board of Trustees and Councilors

(Referred to Reference Committee on Reports of Officers)

At the end of July 1975, Society members had contributed $9,546 to the fund to relocate and reconstruct the Benjamin Rush House, the Society's official Bicentennial project, described in a section of the Board's report under "Significant Actions."

At its August 1975 meeting, the Board determined that the cost of the mailing, which was sent to members in the spring to solicit contributions, would be absorbed by the Society as a contribution to the Benjamin Rush House Committee's efforts. The cost was allocated to the Communications Division's budget.

Society members are encouraged to support the restoration of the Benjamin Rush House by sending in their contributions. One-hundred fifty thousand dollars is needed for this project.

Please see the Supplemental Report of the Board of Trustees and Councilors which lists major items acted upon by the Board at its August meeting for other Society activities planned for the Bicentennial.

Appendix F

Supplemental Report D
Board of Trustees and Councilors

(Referred to Reference Committee on Reports of Officers)

At its August 1975 meeting, the Board of Trustees took action on a number of items which are of interest to the House of Delegates but which require no specific action. The Board of Trustees takes this opportunity to inform the House of Delegates of some of the major actions taken at that meeting. Items which require House action will be in additional supplemental reports. The actions are:

1. Approved the recommendation of the Council on Education and Science that an Advisory Committee on Continuing Education be established, composed of various outside organizations, to keep the council in tune with ongoing educational activities and programs throughout the Commonwealth. The group will be invited once a year to a council meeting at their own travel expense to participate in an educational forum.
2. Approved in principle and referred to the Publication Committee the recommendation that there be a special issue of PENNSYLVANIA MEDICINE and PHILADELPHIA MEDICINE depicting 200 years of medical history in Philadelphia, Pennsylvania, and the United States.
3. Approved the recommendation that the Society request cooperation from the College of Physicians of Philadelphia for a scientific program on September 15, 1976, and support this program through promotion and any embellishment that may be necessary to attract physicians attending the House of Delegates meeting or who are interested in the Bicentennial celebration. The majority of the program will be funded through a grant from Merck, Sharp and Dohme to the College of Physicians of Philadelphia. It may be necessary for the Society to pay the cost of the meeting room and some reception expenses.
4. Referred to the Communications Division the question of Society involvement in the 1976 Bicentennial celebration. The Communications Division is to return with cost estimates for a package of activities to the October Board meeting.
5. Approved the recommendation that the Council on Education and Science seek monies through its contacts with pharmaceutical companies to support: (1) a $25,000 film depicting the history of medicine in this country to be shown at medical meetings in Philadelphia next year; (2) a multimedia slide program promoting major historical medical sites in Philadelphia; and (3) any appropriation to help support a $60,000 medical exhibit at the College of Physicians in Philadelphia.
6. Approved the following policy statement on recertification: "Any PMS member who has passed a recertification examination of a national board will be considered to have met the continuing medical education requirement for membership in this Society for that period." See the report of the Council on Education and Science for more information.
7. Adopted the position statement on marihuana which is printed in the report of the Council on Education and Science.
8. Determined to allocate $2,000 from the Medical Defense Fund to cover preparation, filing and other costs that the Society may incur in the professional stock tax valuation case since its outcome could have an effect on PMS members. The State's Department of Revenue and the Department of Auditor General assign a value to corporation's assets for the purposes of taxation. In the case of physician corporations, the value of profits set aside for profit sharing plans and contributions to pension plans are also included, thereby imposing a higher tax burden on physicians.
   The Society entered the case "of counsel" of Ophthalmic Associates of Johnstown on behalf of PMS members since their petition for review was turned down. Our counsel and their counsel are working with the Department of Revenue's counsel to develop a "stipulation of facts" to present to the Commonwealth Court. Since an agreement has nearly been reached, an oral argument and the filing of briefs will probably occur soon.
9. Determined to continue with one WATS line into the Council on Medical Service for another four months at a cost of approximately $1,300, after which a study will be made of the utilization of the line and the determination as to the need for its continuation can be made at that time.
10. Approved the recommendation of the Committee on Quackery that approximately $1,500 be allocated from the Quackery Defense Fund for a mailing to high school and college guidance counselors for the purpose of educating them to the problems of chiropractic and offering a free copy of "At Your Own Risk," the mailing to be reviewed by the Executive Committee first.
11. Determined to annually send copies of the book, "At Your Own Risk," to all freshman medical students in the state, with an allocation of $1,000 per year for this project from the Quackery Defense Fund. A return card will be enclosed with the mailing to pose pertinent questions as to the value of the book.
12. Allocated $4,500 from the Quackery Defense Fund for the development of six health education radio spots on the subject of "Nutrition Sense and Nonsense."
13. Referred to the Committee on Constitution and Bylaws consideration of a possible lowering of the time limits for calling a special session of the House of Delegates.
14. Authorized the chairman of the Board to appoint a new ad hoc committee to study the question of unionism for physicians, as expressed in the recommendation in the Committee on Objectives.

Appendix G

Supplemental Report E
Board of Trustees and Councilors

(Referred to Reference Committee on Medical Service A)

At its July 20 special meeting, the Board was mainly concerned about actions resulting from the Special House of Delegates Session earlier in July.

However, one major item considered was the Eye Examination and Refraction Program proposed by Pennsylvania Blue Shield. Blue Shield developed this program as a result of pressure to market such a program as an employee fringe benefit. The Council on Medical Service investigated this prepaid program, was aware that such services are being offered by Vision Services Associates and that there is continued pressure on Blue Shield to provide such a program. In May 1974 the Council recommended and the Board approved that Pennsylvania Blue Shield undertake a feasibility study directed toward the provision of a meaningful and clearly defined vision care program which would be satisfactory both to Pennsylvania ophthalmologists and optometrists.

In January 1975 the consensus of a joint Executive Committee meeting of Blue Shield and the Society was that Blue Shield should not become involved in it since it did not conform to traditional insurance principles and was limited to refractions and eyeglasses.

The Blue Shield staff met with representatives of the Pennsylvania Academy of Ophthalmology and Otolaryngology (PAO&O) and the Society in late February to resolve differences. The proposed program was revised with input from the Society, the PAO&O, and the Pennsylvania Optometric Association.

However, the PAO&O rejected it at its business meeting in May because it was felt not to be in the public interest and since it is not a medical program. The PAO&O passed a resolution that it consider a medical visual care program similar to the "Medical Eye Care Foundation of Colorado."

There has been controversy over whether Blue Shield is legally obliged to include optometrists in the program and whether their inclusion would impair the contract between Blue Shield and its physician members.

The academy expressed concern about the optometrists' statement in a position paper to the State Advisory Council on Comprehensive Health Planning that optometrists should "assume a greater responsibility in the diagnosis and treatment of eye disease" and which relegated ophthalmologists' care to secondary and tertiary levels.

Blue Shield asked for the Society's position on the PAO&O's letter to Blue Shield rejecting the proposed program. At its July 20 meeting the Board determined to inform Blue Shield that it did not endorse the program since it appeared to lack conformity with traditional insurance principles and appeared to be inefficient in terms of cost-benefit ratios. The program appeared to have marketing appeal but is not in the public interest since financial savings would not accrue to the individual subscriber nor is the scope of benefits significant.

Appendix H

Supplemental Report F
Board of Trustees and Councilors

(Referred to Reference Committee on Reports of Officers)
Implementation of Actions of the House of Delegates Special Session

This report describes the actions on recommendations which passed the House of Delegates at its special session on July 2-3, 1975. It follows the order of the reference committee's report, except where otherwise noted.

Nearly all of the actions taken by the Board of Trustees at its July 20, 1975, meeting are mentioned since the subject of that meeting was implementation of special session actions.

Resolutions Relating to Corrective Legislation

No. 1—Approved the recommendation of the reference committee as amended. The amended recommendation reads: "Approved resolutions 75-S-7, 75-S-12, 75-S-16, 75-S-25, and 75-S-26, and also that the Board of Trustees be urged to send materials to members detailing the methods by which we can influence our patients and legislators, and that we also set up a specific day and date for a statewide mass demonstration to inform the public of the magnitude of the problem."
The resolved portions of the resolutions follow:

75-S-7

RESOLVED, We physicians of Lehigh County support in principle House Bill 805 now under consideration in the Judiciary Committee; and be it further *RESOLVED*, We strongly urge its swift passage and immediate implementation in order to alleviate the current Malpractice Liability Insurance Crisis now present throughout our state.

75-S-12

RESOLVED, That we strongly support the efforts of Pennsylvania legislators to expedite the provision of medical care by implementing H.B. 805.

75-S-16

RESOLVED, The Pennsylvania Medical Society continue to forcefully support Bill 805 or other legislation with similar provisions so as to effect the needed changes in the present malpractice liability system.

75-S-25 and 75-S-26
(Resolved portions are identical)

RESOLVED, That appropriate legislation be supported at the state level to protect the public from this aspect of runaway health care costs; and be it further

RESOLVED, That only legislation which includes the provisions of H.B. 805 can correct the problem as well as

prevent an otherwise inevitable crisis in the provision of medical care; and be it further

RESOLVED, That every reasonable resource of the Pennsylvania Medical Society continue to be used to support the passage of H.B. 805 in an effort to obtain a fair restraint on medical liability verdicts and a better control of errant medical practitioners; and be it further

RESOLVED, That public relations efforts be directed away from the false label of a "doctor strike" to the true designation of H.B. 805 as a "Peoples Bill" and be it further

RESOLVED, That a concerted and systematic attempt be made to enlist the general public, representatives of labor, industry, commercial insurers, parent-teacher, and fraternal organizations to attend the hearings on H.B. 805 and H.B. 1367 and request support from their legislators for Representative William Shane's H.B. 805.

Implementation—The Society devoted extensive efforts to the passage of H.B. 805. Organizations of retired people, the steelworkers, business and professional women, and others were enlisted in these efforts.

When it became apparent that the House of Representatives would act only on H.B. 1367, the Society undertook extensive efforts to have amendments embodying the key concepts of H.B. 805 added to H.B. 1367. These efforts met with partial success in the House, which passed an amended version of H.B. 1367 and sent it to the Senate, where it now rests with the Senate Insurance Committee. Efforts to amend the bill continue.

Materials detailing the way members can influence both patients and legislators have been distrubuted. These include pamphlets for use in the physician's waiting room, sample newspaper ads, and aid in preparation for public speaking, whether in person or through the media of radio and television. Each county society appointed an 805 Committee, and these groups have been invaluable in contacting the Legislature.

The Board of Trustees and Councilors considered its authority to call for a statewide mass demonstration and determined to withhold such action until such time that our legislative efforts prove inadequate.

No. 2—Approved Resolution 75-S-3, restructuring an Arbitration Panel in HB 805.

The resolved portion of the resolution follows:

RESOLVED, That the voting members of the Panel should consist of three physicians and the judgment of the Panel should be reached by majority vote. One physician should be selected by the plaintiff, one should be selected by the defendant, and a third should be selected by the preceding two, if necessary, at random from those in practice in the jurisdiction. The Panel should have a practicing attorney as its nonvoting chairman who will also serve as legal advisor to the Panel. The attorney-chairman shall be selected jointly by the physicians designated by the plaintiff and defendant or, if necessary, at random from those practicing law in the jurisdiction; and be it further

RESOLVED, That if either side wishes to carry the case to Court, the proceedings and decisions of the Panel are to be admissible as evidence.

Implementation—As mentioned previously, lobbying efforts to amend H.B. 1367 to make it acceptable legislation continue. This change is one of the amendments the Society is attempting to put into H.B. 1367.

No. 3—Referred Resolution 75-S-19 calling for a two trial system to the ad hoc committee on malpractice.

The resolved portion of the resolution follows:

RESOLVED, That the Lycoming County Medical Society urge the Pennsylvania Medical Society, on behalf of the public good of our community and Commonwealth, to seek as one of its points for presentation to the Legislature to be written into the needed new malpractice law that in the event of a law suit following arbitration, that the present all inclusive trial be eliminated and the two trial system substituted, which would include a preliminary trial to determine whether in fact malpractice or maloccurrence occurred, and if malpractice was determined to have occurred, a second trial or hearing then be set to determine damages to the patient.

Implementation—This resolution has been reviewed by the ad hoc committee, which is currently developing language to amend H.B. 1367 for presentation before the Senate Insurance Committee.

Resolutions Relating to Insurance Premium Rollbacks

No. 4—Approved the recommendation of the reference committee, as amended, that the Board of Trustees be directed to examine the justification of the rate structure currently in effect and to report back to this House of Delegates by or before October 1975 on the appropriateness of such rates and on remedial action to reduce such rates, if appropriate.

(This item was considered together with the next item, No. 5, at the special meeting of the Board of Trustees on July 20, 1975. The full report of actions taken on House actions No. 4 and No. 5 follows action No. 5.)

No. 5—Referred to the Board of Trustees Resolutions 75-S-2, 75-S-5, 75-S-8, 75-S-15, and 75-S-17, with the further recommendation that the Board of Trustees look into the feasibility of an action for full disclosure of information needed to review rate increases, and report to the House of Delegates not later than October.

The resolved portions of the resolutions follow:

75-S-2

RESOLVED, That the Bucks County Medical Society urge the Pennsylvania Medical Society, on behalf of the public good of our community and Commonwealth, seek an injunction in Federal Court on the Argonaut Insurance Company to roll back premiums as they existed on an appropriate date prior to April 1, 1975."

75-S-5

RESOLVED, That the Pennsylvania Medical Society bring legal action to enjoin said Insurance Company to roll back its premiums to the March 31, 1975 level.

75-S-8

RESOLVED, That at the moment that we have meaningful legislation passed by the Legislature and enacted into law, that we have an immediate rollback of malpractice insurance premiums to those premims that were in effect as of January 1, 1975.

75-S-15

RESOLVED, The Pennsylvania Medical Society shall request the appropriate Commonwealth authorities to mandate all malpractice insurance rates be frozen as of March 1, 1975, until appropriate legislation becomes effective and based on this legislation, new rates are established by the insurance companies and the Insurance Commissioner of the Commonwealth of Pennsylvania.

75-S-17

RESOLVED, That the Pennsylvania Medical Society file a complaint with the Pennsylvania Insurance Department and request a hearing with regard to the justification of granting Argonaut Insurance Company a 206% rate increase in malpractice premiums.

Implementation—At the special meeting on July 20, 1975, the Board considered these two House actions. It referred them to the Commission on Professional Liability Insurance for study. The Commission is to return to the Board with a draft supplemental report to the House of Delegates for review by the Board at or before the October session of the House of Delegates. See the supplemental report of the Board, which is issued after its October meeting.

No. 6—Rejected Resolution 75-S-18 but approved the recommendation of the Reference Committee that the Durkin Report continue to be made available at the State Medical Society headquarters building for the personal perusal of any interested PMS member.

Implementation—The Durkin Report is currently available at Society headquarters for examination by any interested member of the Society.

No. 7—Approved Resolution 75-S-28 that the PMS poll Argonaut insureds to ascertain their feelings with regard to PMS reactions to Argonaut rate increases.

The resolved portion of Resolution 75-S-28 follows:

RESOLVED, That the Pennsylvania Medical Society shall poll those physicians insured by Argonaut forthwith to ascertain their true feeling.

Implementation—The author of this resolution made two suggestions to the House. One, that the proposed questionnaire accompany either the proceedings of this Special Session or the next President's Letter, whichever comes first, and further, that the results of the questionnaire be published to the members as soon as possible. This resolution was reviewed by the Board at its special meeting of July 20, 1975, and authority to conduct the survey given to the Commission on Professional Liability Insurance. The poll was mailed from Society headquarters on Friday, August 8, 1975. Results of the poll were published in the September issue of PENNSYLVANIA MEDICINE.

No. 8—Approved Resolution 75-S-30, that PMS petition the Insurance Commissioner to release information used to justify rate increases.

The resolved portion of the Resolution follows:

RESOLVED, We urge the Pennsylvania Medical Society to petition the Insurance Commissioner of Pennsylvania to release to the public, and notably to the press, the relevant information available to the Commissioner's office to justify these increases.

Implementation—Correspondence from the President was prepared, however, since the information involved is the subject of the Insurance Commissioner's rate review hearings set for September and which will be open to the press and the public, our own petition seems unnecessary.

Resolutions Relating to Methods for the Accomplishment of Desired Legislation

No. 9—Approved the recommendation of the Reference Committee that recommendation No. 3 from the president's address be approved, namely, that physicians use a written agreement signed prior to acceptance of patients for settlement of patient dissatisfaction to binding arbitration, the mechanism and form to be implemented as soon as feasible by the Board of Trustees.

Implementation—Action to implement this decision of the House is well under way. Both the Society's and the Hospital Association of Pennsylvania's (HAP) ad hoc committees on malpractice and staff have met jointly several times. HAP was asked to participate since the agreement will usually be signed in a hospital setting when the patient is admitted. A representative of the American Arbitration Association was invited to attend a joint meeting of the staffs of both organizations to give advice. The agreement will go before the HAP Board of Directors in September for an opinion. PMS legal counsel will be present. The matter will then go to the Society's Board of Trustees.

No. 10—Approved the recommendation that the Pennsylvania Medical Society use the Medical Defense Fund to cover legal costs of prosecution of meritorious "abuse of process" cases on behalf of physicians who have successfully defended against a malpractice charge and that the Board of Trustees be authorized to make a mandatory assessment of each member in an appropriate amount, the purpose being for general use in aiding in the malpractice liability problem. The Board considered this action, together with Resolution 75-S-13, next, which also calls for an assessment, at its special meeting of July 20, 1975. The Board's response is reported after the next House action.

No. 22—Approved Resolution 75-S-13 regarding a possible assessment.

The resolved portion of this resolution follows:

RESOLVED, That organized medicine pursue all forms of publicity, including the press, radio, and TV to state our case on the malpractice insurance problem in an effort to secure passage of HB 805; and be it further

RESOLVED, That the Pennsylvania Medical Society make an effort to enlist the support of labor for our position; and be it further

RESOLVED, That the Pennsylvania Medical Society consider placing an assessment on each member to finance the cost of the program, if necessary.

Implementation—The actions of the House authorizing a special assessment were reviewed by the Board at its special meeting of July 20. The Board saw no pressing need for a special assessment at that time.

The Society has pursued all forms of publicity and has

urged county societies to do so in addition to providing them with material.

No. 11—Approved the recommendation of the Reference Committee that recommendation No. 1 from the address of the president be referred back to the Board of Trustees for further study and report back to the House of Delegates by or before October 1975. The suggestion was made that the Board poll the state's physicians to determine in what type of action they would participate.
Recommendation No. 1 from Dr. Crane's address reads as follows:

> That until such time as significant legislation is enacted: (a) Physicians will continue to provide medical care but will withdraw as participants in all insurance programs, will accept no assignments and will execute no payment forms. (b) No medical reports will be rendered by physicians to attorneys in cases relating to claims for medical disability. (c) Physicians will refuse to testify on an adversary basis in cases claiming medical disability.

(This was considered by the Board together with House Action No. 19, which is next. The implementation report on both of them follows that action.)

No. 19—Referred to the Board of Trustees for study and report back to the House by or before October 1975, in a similar manner to recommendation No. 1 from the address of the president, the subject matter of the second resolved clause of Resolution 75-S-29 (paper work stoppage).
The referred portion of the Resolution follows:

Do not sign papers or give medical opinions where full legal implications are not fully understood:

a. Death certificates
b. Birth certificates
c. Wasserman Tests for Marriage
d. Driver's License unless job depends on it
e. Examinations for life insurance
f. Immunization records for school and passports
g. Permission to play school sports or take physical education
h. Utilization Committee reports
i. Peer Review
j. Accident reports for police
k. Professional witness at trials
l. Withholding of medical forms till 60-day period is up.

Implementation—At the Board meeting of July 20, a committee of the staff was directed to study the proposed actions, together with staff from HAP, and report back with implications of the proposed actions. A report is being prepared.

No. 12—Declared that it is unethical for a physician to accept a fee for medical testimony and referred the matter to the Judicial Council for adjudication.

Implementation—The Judicial Council has been informed of this decision by the House and will render a report to the House of Delegates by the October meeting.

No. 13—Adopted a substitute resolution for Resolutions 75-S-1, 75-S-9, 75-S-23, and 75-S-27.
The substitute resolve reads:

That the Pennsylvania Medical Society advise the Governor, the state legislators, and the people of Pennsylvania, who are our patients, the type of malpractice legislation now being considered by the Legislature will not correct the malpractice problem and is totally unacceptable to Pennsylvania physicians. Failure of the Legislature to recognize this fact and to enact legislation embodying the concepts of Bill 805 will be countered by future stern measures of increasing magnitude.

Implementation—The people of Pennsylvania have been made aware of the malpractice crisis and our Society's views regarding remedial legislation by press releases from the Society and public statements by Society officers.

Draft correspondence to the legislators and the Governor is being prepared and will be held in readiness should our current legislative efforts prove fruitless.

No. 14—Adopted Resolution 75-S-21 with the amendment recommended by the Reference Committee.
The amended resolution follows:

RESOLVED, That if adequate corrective legislation is not forthcoming as determined by the Board of Trustees that this special session of the House of Delegates be reconvened to give serious consideration to the matter of a statewide slowdown at the appropriate time.

Implementation—The Board received this action by the House for information at its meeting of July 20. Later it appeared that a reconvening would be necessary, so a special session was scheduled. Encouraging progress in the Senate Insurance Committee regarding amendments caused a postponement of the second special session.

No. 15—Adopted Resolution 75-S-14, Means of Protesting Intolerable Burdens.
The resolved portion of the resolution follows:

RESOLVED, That the primary commitment of the Cambria County Medical Society and its physician members is to the essential medical needs of the people of this community; and be it further

RESOLVED, That the Cambria County Medical Society recognizes that it is the inalienable right of physicians to decide for themselves the circumstances under which they can or cannot continue to practice their profession; and be it further

RESOLVED, That the Cambria County Medical Society recognizes that physicians are entitled to use all available legal means, without jeopardizing the medical care of their patients, to protest when intolerable and unwarranted burdens are placed upon their patients, the society, or its members; and be it further

RESOLVED, That the Pennsylvania Medical Society consider adoption of this policy statement at the Special Session of the House of Delegates; and be it further

RESOLVED, That the Pennsylvania Medical Society continue to study the effects of changing socioeconomic conditions on the ability of physicians to practice medicine.

Implementation—Ongoing study of the effects of changing socioeconomic conditions on the ability of physicians to practice medicine is a responsibility of the Council on Medical Service.

No. 16—Adopted Resolution 75-S-11, withholding of services not in the best interest of patients.
The resolved portion of the resolution follows:

RESOLVED, That this House of Delegates affirm that the concept of withholding of service as a socioeconomic alternative is a reaction not in the best interest of patients; and be it further

RESOLVED, That if no valid answer to the liability crisis is obtained by the next general session of the House of Delegates, October 1975, the Pennsylvania Medical Society shall consider other sanctions to support our position and the public interest with regard to the professional liability crisis.

Implementation—The resolved portion of this resolution will be put before the House again for action if no relief has been obtained for the malpractice crisis by October 1975.

No. 17—Adopted Resolution 75-S-10, development of a plan for emergency medical services in the event of a forced curtailment of medical services.
The resolved portion of the resolution follows:

RESOLVED, That a plan for the emergency care of the people of Pennsylvania be drawn up by the Board of Trustees of the Pennsylvania Medical Society for implementation in the event of forced curtailment of medical services.

Implementation—At its August meeting the Board approved the recommendation of the Commission on Emergency Medical Services that the contingency emergency care plan presented in its report be disseminated to county medical society presidents, presidents of medical staffs, and county medical society executive secretaries, but that the local task forces it called for not be activated until deemed necessary by the Board of Trustees. A letter will be sent shortly to those indicated above.

Miscellaneous Resolutions

No. 18—Rejected Resolution 75-S-4, endorsement of defensive medicine, and the first clause of Resolution 75-S-29, extreme defensive medicine.

No. 20—Approved Resolution 75-S-22, counterclaim for abuse of process.
The resolved portion of the resolution follows:

RESOLVED, That the Pennsylvania Medical Society join with certain member-defendants (in malpractice suits deemed by the Pennsylvania Medical Society to have little merit) to counter claim for abuse of process.

Implementation—The decisions as to which suits to join rests with the Board of Trustees, which will make a case by case determination of any such requests brought before it.

No. 21—Rejected Resolution 75-S-6, urging that representatives of high risk specialties sit with the Board of Trustees until the malpractice crisis is resolved.

No. 23—Rejected Resolution 75-S-20, calling for a malpractice insurance surcharge on all bills, but adopted the recommendation that physicians use their best judgment regarding this practice.

No. 24—Approved Resolution 75-S-24, development of insurance corporation as a contingency, in view of the fact that it conforms with recommendation No. 5 of the Address of the President.
The resolved portion of this Resolution follows:

RESOLVED, That if this proposal receives an affirmative vote from the delegates, it be referred to a special committee for detailed formulation as a contingency or optimal solution of the present insurance problem.

Implementation—The Commission on Professional Liability Insurance is currently developing such a contingency plan for use should other efforts prove fruitless. At the Board's June 25 meeting, it approved the recommendation of the Commission on Professional Liability Insurance that PMS authorize funds ($5,000) for the development of a proposal for self-insurance to be coordinated and overseen by the Commission on Professional Liability Insurance.

Other Board Actions Relating to the Malpractice Insurance Crisis

The subject of the June 25 special board meeting was the preparation for the Special Session. Two relevant actions, otherwise not reported in this report, are: the allocation of an additional $25,000 to the malpractice account to cover the cost of legal fees related to the malpractice crisis for the remainder of the year; and the allocation of an additional $2,000 from the General Fund for postage. This makes the current budget of the malpractice account $432,000.

Major actions of the August 12-13 Board meeting are reported in a separate supplemental report.

Appendix I

Supplemental Report G
Board of Trustees and Councilors
(Referred to Reference Committee on Medical Service A)

At the Special Session of the House of Delegates, July 2-3, 1975, a series of actions were proposed, their goal to "screw up the system" via a variety of actions. The actions adopted by the House for research and report back by the Board of Trustees had their genesis in the report of the president and in Resolution 75-S-29. They are:

A. No medical reports will be rendered by physicians to attorneys in cases relating to claims for medical disability.

B. Physicians will refuse to testify on an adversary basis in cases claiming medical disability.

C. Physicians will conduct a "paperwork stoppage," including:

1. Death certificate
2. Birth certificate
3. Wasserman tests for marriage
4. Drivers' licensing exams, unless job depends on it

5. Exams for life insurance
6. Shot records for school and passports
7. Permission to play school sports or take physical education
8. Utilization committee reports
9. Peer review
10. Accident reports for police
11. Professional witness at trials
12. Withholding of medical forms until 60-day period is up

This supplemental report depicts the probable impact of each of these actions, should it be adopted.

A. No medical reports will be rendered by physicians to attorneys in cases relating to claims for medical disability.

B. Physicians will refuse to testify on an adversary basis in cases claiming medical disability.

The effectiveness of these actions would be directly related to the effectiveness of the boycott as measured by the number of physicians participating. The larger the number of physicians who refuse to give medical opinions to attorneys, the greater the practical impact on litigation involving medical disability. It must be anticipated that medical opinions would be available from non-participating physicians, medical or osteopathic. Federal and state rules of civil procedure may be invoked to compel testimony as to the facts of medical treatment, but opinions as to the correctness of the treatment could not be forced.

The inconvenience to attorneys must be evaluated in the context of the time available to them to handle most of the litigation involving medical disability claims, and weighed against the inconvenience to the boycotting physician. The inconvenience to the boycotting physician who had been engaged in treatment may be as great as any inconvenience suffered by an attorney. The time available to handle litigation involving medical disability claims under normal circumstances is such that the impact of a decision to refuse testimony and written medical opinions is open to question. If medical testimony is unavailable, attorneys faced with this problem may seek continuance of their cases until the testimony becomes available.

Death Certificate

The source of information on this subject, and most of the others dealing with the paperwork stoppage, was *Purdon's Pennsylvania Statutes Annotated.* Under the Vital Statistics Act, Volume 35, Section 450, it states that in most cases of death, there is a requirement for a "physician who attended the deceased during the last illness, and in the case of a fetal death, by the attending physician," to supply medical certification to the person in charge of interment or removal of the dead body. In cases where no physician was in attendance, or where the physician is physically unable to supply the necessary data, the local registrar or person in charge of interment or removal of the body shall refer the case to the coroner. These requirements are found respectively in Sections 450.502 and 450.503. There is documentation that physicians have been compelled to fill out such certification or face the penalties provided in the law. Section 450.901 provides penalties, consisting of a fine of not less than $50 or more than $300 together with costs, and in default of payment, imprisonment in the county jail for not more than thirty days.

Birth Certificate

Material dealing with birth certificates is found in Section 450.401 of Purdon's. This provides that the certificate shall be prepared, signed and filed by the attending physician and makes provisions for the case when there is no attending physician. Further, it provides that in the absence or disability of all persons named in the section, the local registrar may designate a person acquainted with the facts to fill out the birth certificate. Thus, it would seem that a paperwork stoppage here would not prevent the issuance of birth certificates. Penalties for non-compliance are identical to those listed above for failure to fill out the death certificate; a fine of not less than $50 or more than $300, together with costs, and in default of payment, imprisonment in the county jail for not more than thirty days.

Wasserman Tests for Marriage

Restrictions on the issuance of marriage licenses are covered in the Marriage Law, Purdon's Volume 38, Sections 1-5 and 1-6. There is a requirement that no license to marry shall be issued until the clerk of the Orphan's Court has in his possession a statement signed by a duly licensed physician of the Commonwealth of Pennsylvania, or any commissioned medical officer in the United States Army or Navy, or any physician of the Public Health Service of the Federal Government, that each applicant has within thirty days submitted to an examination to determine the existence or non-existence of syphilis, and that in the opinion of the examining physician, the applicants are not infected with communicable syphilis. There is a provision in Section 1-6 that if the applicant has been denied a physician's statement he has a right to appeal to the Department of Health, which may issue or refuse to issue a statement in lieu of the physician's statement required by Section 1-5 of the Act.

The requirement for premarital examination for syphilis also appears in the Disease Prevention and Control Law of 1956 (35 P.S. § 521.1 et seq). That Act and the regulations issued under its authority (28 Pa. Code § 27.1 et seq) generally require physicians to report instances of communicable diseases to health authorities. A physician who refuses to report finding venereal disease in an examination made for syphilis in connection with marriage license issuance may be subjected to the penalties provision of the Act, 35 P.S. § 521.20, providing for fines of between $25 and $300 and for failure to pay a fine, imprisonment up to thirty days.

Driver's Licensing Exam, Unless Job Depends on It

The requirement that an applicant for a driver's license have a physical examination can be traced to Section 608 (g) of the Motor Vehicle Code (75 P.S. § 608 (g)). The exact requirements are found in regulations, which do not impose any duty on physicians to report. They apparently do not permit any substitution for a physician's report.

There are, of course, some whose jobs depend on physician exams, such as school bus drivers, but the House action as adopted sought to avoid situations which would jeopardize patients' employment.

Exams for Life Insurance

Requirement for physician exams as a prerequisite for issuing life insurance is a matter of individual company policy. Should physicians refuse to give these exams, the insurance companies would probably not issue policies until such a time as the physician's paperwork stoppage is settled and physician examinations are once again available.

Some physicians may have contractual arrangements with insurance companies or agents, which would be breached by a boycotting physician.

Shot Records for School and Passports

Volume 24 P.S. 513-1303 (a) of Purdon's Section 13-1303 (a) reports the requirement for smallpox vaccination of children before their admission to school. A certificate verifying vaccination must be signed by a physician. Should the physician not sign the certification, apparently the child would not be admitted to school. A fine of not less than $5 nor more than $100 is provided for anyone violating the provisions of the Section. It is interesting to note that there is no specification as to which physician must sign the certification, i.e., family physician, school physician, child's physician at time of vaccination, etc.

The Department of Health has adopted rules to implement Act 66 of 1974, which calls for immunization of school children against several serious communicable diseases. Of note is the provision that the duty of insuring immunization falls to school directors, superintendents, principals, or others in like administrative position. Administrative guidelines as to appropriate methods for insuring compliance with the immunization regulations will be issued by the Department of Health, and may require physician certification.

Permission to Play School Sports or Take Physical Education

24 P.S. § 5-511 reports that the board of school directors in the school district has authority to prescribe and enforce rules and regulations governing physical education and school sports. Thus, the impact of physicians refusing to sign permission for school physical education classes and extracurricular activities would depend upon the rules adopted by the various school districts. It might also be possible for the school district to circumvent the effects of the paperwork stoppage by changing their rules and regulations.

Utilization Committee Reports

Should physicians stop their utilization committee work, this would constitute a violation of medicare and medicaid regulations by the hospital, and it would also result in the cessation of medicare and medicaid payments to both physicians and hospitals. The impact of such action would fall most heavily on the hospitals, which are dependent on an uninterrupted flow of payments.

Peer Review

The first impact of physicians refusing to do peer review would be to put hospitals out of compliance with the requirements of medicare and third party payors. These parties would probably threaten to stop payments to hospitals, which may by law turn to outside contractors to carry out the peer review activities.

Accident Reports for Police

There seems to be no requirement that physicians fill out such accident reports. The closest requirement is for physicians to take blood samples for the purpose of determining alcohol concentration. It is worth noting that this test may be administered either by a physician, a technician, or by a police officer who has received training in the technique. Thus, physician refusal to draw blood samples would have impact only if there are not a sufficient number of technicians or police officers who have this training and equipment available. Purdon's notes that "although it is better in drunken driving cases to have medical testimony or chemical tests, the law makes no requirement that such expert evidence be produced on this subject."

A physician's outright refusal to test for alcohol concentration might be considered "obstructing" the administration of justice, a misdemeanor of the second degree (18 P.S. § 5101). The law provides a penalty of up to a $5,000 fine or two years imprisonment.

The Pennsylvania Criminal Code also provides that a physician failing to report injuries by firearm or criminal act commits a summary offense. (18 P.S. § 5106) The law provides a maximum fine of $300 and a jail term of up to 90 days.

Withholding of Medical Forms Until 60 Day Period is Up

With reference to medicare, the physician might stop accepting assignments, and stop filling out patient certification forms. The impact of this would be a lack of payment from medicare to the patient, thus putting the burden for payment of medical bills strictly on the patient with no recourse to medicare.

Other

There are many other segments of the law in which a "paperwork stoppage" by the physicians would have an impact. These are too numerous to list in their totality here, and only two examples are listed here.

As specified in 43 P.S. § 404 every bakery employee must be examined at least once every six months by a physician who shall certify freedom from disease or affliction, the records to be kept in the bakery. If physicians stopped rendering such reports, the affected employees would probably be laid off and eventually bakery operations would come to a stop. The law appears to provide no penalties against an individual physician who refuses to provide such certification.

Results of Poll of Argonaut Insureds

(See Appendix J)

1. What is your professional liability rating classification?

TERRITORY I		*TERRITORY II*		*NO TERRITORY LISTED*		*GRAND TOTALS*	
Class I	266	Class I	390	Class I	3	TERRITORY I	657
Class II	37	Class II	73	Class II	0	TERRITORY II	862
Class III	39	Class III	89	Class III	0	UNSPECIFIED	5
Class IV	116	Class IV	142	Class IV	0		1524
Class V	199	Class V	168	Class V	2		
TOTAL	657	TOTAL	862	TOTAL	5		

2. Do you feel the premium you pay for professional liability insurance is commensurate with the financial protection it affords you?

TERRITORY I

	Yes	*No*	*No Comment*
Class I	133	119	14
Class II	13	24	0
Class III	10	27	2
Class IV	14	99	3
Class V	27	167	5
TOTAL	197	436	24

TERRITORY II

	Yes	*No*	*No Comment*
Class I	228	145	17
Class II	29	42	2
Class III	29	54	6
Class IV	33	103	6
Class V	54	112	2
TOTAL	373	456	33

NO TERRITORY LISTED

	Yes	*No*	*No Comment*
Class I	2	1	0
Class II	0	0	0
Class III	0	0	0
Class IV	0	0	0
Class V	0	2	0
TOTAL	2	3	0

GRAND TOTALS

	Yes	*No*	*No Comment*
TERRITORY I	197	436	24
TERRITORY II	373	456	33
UNSPECIFIED	2	3	0
	572	895	57

3. Would you urge the Pennsylvania Medical Society to bring legal action against Argonaut to effect a roll back of premiums, even if such action entailed the risk that Argonaut might leave the State of Pennsylvania?

TERRITORY I

	Yes	*No*	*No Comment*
Class I	57	204	5
Class II	15	21	1
Class III	9	29	1
Class IV	58	57	1
Class V	125	70	4
TOTAL	264	381	12

TERRITORY II

	Yes	*No*	*No Comment*
Class I	57	325	8
Class II	13	59	1
Class III	21	67	1
Class IV	50	91	1
Class V	55	110	3
TOTAL	196	652	14

NO TERRITORY LISTED

	Yes	*No*	*No Comment*
Class I	2	1	0
Class II	0	0	0
Class III	0	0	0
Class IV	0	0	0
Class V	2	0	0
TOTAL	4	1	0

GRAND TOTALS

	Yes	*No*	*No Comment*
TERRITORY I	264	381	12
TERRITORY II	196	652	14
UNSPECIFIED	4	1	0
TOTALS	464	1034	26

There is a requirement that every employer carrying on any work in which persons are employed in compressed air shall employ a physician as a medical officer who shall examine all prospective employees and keep a record of all physical examinations, in order to insure that the employees are physically qualified to work in compressed air. If physicians should cease this type of examination, it would seem that all work in which persons are employed in compressed air would eventually come to a halt.

Appendix J

Supplemental Report H
Board of Trustees and Councilors
(Referred to Reference Committee on Medical Service A)

At its special session on July 2 and 3, 1975, the House of Delegates approved Resolution 75-S-28, that the PMS poll Argonaut insureds to ascertain their feelings with regard to Argonaut rate increases and to determine whether they would favor PMS seeking a roll back of premiums if this action would jeopardize their coverage. The majority of insureds were not in favor (see results of question 3) of action that would run the risk of their losing coverage.

Although these results were originally published in the September issue of PENNSYLVANIA MEDICINE, we have included them here (attached as Appendix A) for the information of the House of Delegates.

Appendix K

Supplemental Report I
Board of Trustees and Councilors
(Referred to Reference Committee on Medical Service A)

The Board of Trustees directed the Commission on Professional Liability Insurance to submit a draft supplemental report to the House of Delegates for review by the Board at or before the October Session of the House. The following report is intended to fulfill that directive:

Much has been written in the past year or so which questions the ability and the integrity of carriers in determining premium levels for professional liability insurance. The Argonaut Insurance Company has received the lion's share of this attention in Pennsylvania, although a variety of carriers is involved in many states.

Nearly all of the professional liability insurance in Pennsylvania is written by three companies—Argonaut, Aetna, and Medical Protective. All three got substantial rate increases in 1975 and the Insurance Services Office (ISO), an independent, non-profit organization that files rates for certain other subscribing companies, currently has a major rate increase request before the Insurance Department.

In each instance, the Pennsylvania Insurance Department conducted a public hearing, which was attended by PMS representatives and testimony was offered where appropriate. The Pennsylvania Insurance Department has the statutory duty to review proposed rates to assure that they are not excessive, inadequate, or unfairly discriminatory. At the same time, one of the department's most vital responsibilities is to assure the continuing ability of insurance companies to pay claims and to remain in a solvent position.

Professional liability insurance presents a different problem actuarially from any other line of insurance. Only under a "claims made" type of professional liability coverage can a company establish its rates retrospectively with any degree of accuracy, since the "claims tail" has been eliminated. Unfortunately, such policies are of benefit to only the insurance companies and those regulating them. Thus, the "occurrence" policy presents the difficult problem of projecting future claims frequency and cost, and regardless of how many actuaries you confront, you will be cautioned that actuaries do not practice an exact science and projections and determinations required by this line of business contain considerable uncertainty and much room for judgement. There are indeed several accepted methods for making projections, but the realities of double-digit inflation, social justice, and consumer awareness diminish their credibility.

The Commission on Professional Liability Insurance was established in early 1971 by the written agreement between PMS, Argonaut and Parker & Company (now Frank B. Hall & Company of Pennsylvania, Inc.), primarily to oversee and coordinate the Pennsylvania Medical Society's Professional Liability Insurance program. One of the specific reponsibilities of the commission was to ". . . review periodically all statistical data compiled and furnished by Argonaut and Parker with respect to rate classifications, premiums, and losses both for rate making purposes and claims prevention . . ." In the early going, Argonaut did provide detailed pertinent statistical data to the commission, but at no time did the company seriously consider the commission as having a role in the settling or defending of individual claims. Unfortunately, detailed claims data which was available initially stopped coming in 1973, and only data of a general nature was received until June of 1975. Now the commission is receiving a variety of exhibits which identify individual claims, payments and reserves by specialty, county, and month. It indicates if a claim is open or closed and whether a reserve has been established. Obviously, some of the information is sensitive, since its release could jeopardize settlement negotiations.

With this new data, we have developed the attached exhibits to enable a better understanding of the status of the overall program and specifically, the appropriateness of the current premium levels. The following definitions may be helpful in understanding the exhibits:

Claim—A file set up and a reserve established and investigation underway;

Incident—A report of an event by an insured where no reserve established;

Exposure—Number of doctors at risk;

Frequency—Number of claims applied against exposure;

IBNR—Incurred But Not Reported; Claims which, based on past experience, can be predicted but have not as yet been reported;

Loss Ratio—Relationship between earned premium and all losses (paid and reserved);

Written Premium—Gross amount of money collected on all policies;

Earned Premium—That portion of written premium that *currently* belongs to company. (Changes each day).

I. PREMIUM INCOME (As of June 30, 1975)

Policy Year	Written Premium	Earned Premium
1971	$ 1,252,061.00	$ 1,252,061.00
1972	2,732,465.00	2,732,465.00
1973	3,620,424.00	3,620,424.00
1974	4,880,118.00	4,376,004.00
1975	8,000,000.00 (projection)	786,983.00
TOTAL	$20,485,068.00	$12,767,937.00

II. INSUREDS BY CLASS AND TERRITORY (As of July 28, 1975)

	Class I	Class II	Class III	Class IV	Class V	TOTAL
Territory I	835	230	89	302	473	1929
	19.6%	5.4%	2.1%	7.1%	11.1%	45.3%
Territory II	950	396	196	371	418	2331
	22.3%	9.3%	4.6%	8.7%	9.8%	54.7%
TOTAL	1785	626	285	673	891	4260
	41.9%	14.7%	6.7%	15.8%	20.9%	100.0%

III. A. CLAIMS* AND INCIDENTS** (As of July 28, 1975)

Policy Year	Number of Incidents	Number of Claims	Claim Reserves	Claims Paid	Total (Paid & Reserved)	Loss Ratio
1971	53	103	$ 1,126,400.	$ 293,073.42	$ 1,419,473.42	113%
1972	115	279	5,146,465.	932,131.51	6,078,596.51	222%
1973	155	233	5,054,100.	68,586.19	5,122,686.19	141%
1974	100	81	1,846,700.	4,451.39	1,851,151.39	42%
1975***	16	1	11,000.	0	11,000.00	1%
TOTAL	439	697	$13,184,665.	$1,298,242.51	$14,482,907.51	113%

* Open with reserves or closed with payment

** Report only - No claim file set up

*** These figures represent claims and incidents presented against policies beginning in 1975. It is entirely possible that as many as 800 claims may be presented against 1975 policies by the year 1982. While Argonaut currently receives between 40 and 50 new claims each month, they are chargeable against previous policy years, due to the slow development of professional liability claims.

III. B. CLAIM FREQUENCY (PER 100 DOCTORS) BY SPECIALTY CLASSIFICATION & TERRITORY (As of May 31, 1975)

Specialty Identification	TERRITORY I Claims	TERRITORY I Frequency	TERRITORY II Claims	TERRITORY II Freqency	COMBINED TERRITORIES Claims	COMBINED TERRITORIES Frequency
Class I						
Physicians - No Surgery	48	2.7	29	1.4	77	2.0
Class II						
Physicians - Minor Surgery	26	7.3	31	3.4	57	4.5
Class III						
Physicians - Minor Surgery/Cardiologists	2	3.2	15	5.7	17	5.2
Ophthalmologists	6	4.6	6	2.1	12	2.9
Proctologists	0	0.0	0	0.0	0	0.0
TOTAL CLASS III	8	3.8	21	3.8	29	3.8
Class IV						
Cardiac Surgeons	2	19.2	1	22.9	3	19.7
Otolaryngologists - No Plastic Surgery	4	4.5	9	12.0	13	7.9
General Surgeon Specialists	90	13.7	51	7.5	141	10.6
Thoracic Surgeons	4	12.2	0	0.0	4	9.2
Urologists	7	5.2	3	2.1	10	3.6
Vascular Surgeons	0	0.0	0	0.0	0	0.0
TOTAL CLASS IV	107	11.6	64	7.0	171	9.3
Class V						
Anesthesiologists	41	10.5	17	8.3	58	9.7
Neurosurgeons	18	22.4	6	11.9	24	18.3
Obstetricians-Gynecologists	51	13.3	16	4.0	67	8.6
Orthopedists	65	18.6	36	13.2	101	16.2
Otolaryngologists - Plastic Surgery	7	9.2	4	4.5	11	6.7
Plastic Surgeons	12	16.9	3	7.3	15	13.4
TOTAL CLASS V	194	14.3	82	7.8	276	11.5
Claims Allocated to Other Classes (Partnerships, Supervisory, etc.)	31		12		43	
TOTAL ALL CLASSES	414	8.9	239	4.3	653	6.4

III. C. CLAIMS ANALYSIS (As of July 28, 1975)

Territory I and II - All Year Totals

Claims	Number Open	Amount	Number Closed	Amount	Total Claims	Total Amount
1971	59	$ 1,126,400	44	$ 293,073	103	$ 1,419,473
1972	212	5,146,465	67	932,132	279	6,078,597
1973	183	5,054,100	50	68,586	233	5,122,686
1974	71	1,846,700	10	4,451	81	1,851,151
1975	1	11,000	0	0	1	11,000
GRAND TOTAL	526	$13,184,665	171	$1,298,242	697	$14,482,907

III. D. CLAIMS BY TERRITORY AND FREQUENCY (Per 100 Doctors) (As of May 31, 1975)

All Years		
Philadelphia County	274	9.8
Other Counties - Territory I	140	7.6
Allegheny County	89	6.8
Other Counties - Territory II	150	3.6
TOTAL	653	6.4

III. **E. CLAIMS SUMMARY BY COUNTY - ALL YEARS** (As of May 31, 1975)

County	Number Open Claims	Dollar Reserve	Average Reserve	Number Closed Claims	Dollar Paid	Average Paid	Number Total Claims	Dollar Total	Average Value
Philadelphia	227	$5,768,915	25,414	47	$ 484,712	10,313	274	$6,253,627	22,823
Bucks	19	403,500	21,237	7	1,070	153	26	404,570	15,560
Chester	4	85,300	21,325	4	742	186	8	86,042	10,755
Delaware	41	594,100	14,490	12	539,805	44,984	53	1,133,905	21,394
Montgomery	46	1,384,875	30,106	7	25,694	3,671	53	1,410,569	26,615
TOTAL TERRITORY I	337	$8,236,690	24,441	77	$1,052,023	13,663	414	$9,288,713	22,437
Allegheny	53	$1,500,950	28,320	36	$ 39,329	1,092	89	$1,540,279	17,307
Other Counties Territory II	111	2,351,125	21,181	39	71,217	1,826	150	2,422,342	16,148
TOTAL TERRITORY II	164	$3,852,075	23,488	75	$ 110,546	1,474	239	$3,962,621	16,580
TOTAL - ALL TERRITORIES	501	$12,088,765	24,129	152	$ 162,569	1,069	653	$13,251,334	20,293

Conclusions

The central question is, "What conclusions can reasonably be drawn from the foregoing information?"

Rate development is largely based on trends—frequency trends and severity trends. There should be no argument that both are increasing. For example, based on PMS experience under the Argonaut program, the average claim value for policy year 1971 was $13,734. The corresponding value for policy year 1974 is $21,198. However, it is fair to argue that Argonaut data is not "mature" enough to be considered "credible." The Pennsylvania Insurance Department recognized this when it granted a 206.9 percent increase to Argonaut in April 1975. The department authorized the use of data from other areas. Interestingly, while there was great sentiment that that increase was not justified, several things have occurred subsequently that support the department's ruling.

It should be remembered that when the latest Argonaut increase was granted, the Insurance Department was looking at a company which was on the verge of insolvency. This was not an Aetna, INA, or Travelers with huge reserve funds and other lines of insurance for stabilization. However, since that increase was granted to Argonaut, the Insurance Department authorized an increase to the Aetna for professional liability insurance which brings their rates significantly higher than Argonaut for Classes I, II and III. The Aetna filing was based on Pennsylvania data, since their experience was "mature" and this suggests that the use of Pennsylvania data alone would tend to justify higher premiums—at least in the eyes of the Pennsylvania Insurance Department. Argonaut data will be five years old in June of 1976.

The most perplexing aspect of this entire matter is the Incurred But Not Reported (IBNR) claim. In June of this year, the Argonaut branch manager wrote to the Commission on Professional Liability Insurance, ". . . By our best current estimates, we have 85 percent of the 1972 claims, 45 percent of the 1973 claims and 10 percent of the 1974 claims now reported. Obviously, the final frequency figures for these years will be dramatically higher than now appears."

The trick, of course, is to be able to predict the value of the claims that have not as yet surfaced. Argonaut now estimates that the current statewide value of an *open* claim is approximately $26,000. There may be some salvage in these reserves, but Mr. Lawrence Baker, president of Argonaut, testified before the Pennsylvania Insurance Commissioner that Argonaut reserves may be high, but if they are, it will be the first time in the history of professional liability insurance that reserves covered ultimate losses.

At this point in time, there simply is no way to conclusively determine that the current Argonaut rate level is excessive. The Insurance Commissioner has approved rates higher than Argonaut rates in subsequent adjudications. It appears, therefore, that there can be no question but that rates will continue to increase and availability of coverage will be problematic until substantial legislative remedies are enacted. The proposal currently under consideration by the Pennsylvania Legislature should help, but additional measures will be required further down the road.

One conclusion that can be made, based on Argonaut data, would be that there appears to be some inequity to the current Pennsylvania rating territories. Suburban Philadelphia counties can argue that they are being forced to subsidize Philadelphia County in Territory I, and similarly, Allegheny County is benefiting through the subsidization by the other counties in Territory II.

The most apparent inequity applies to Chester County and to a lesser degree, Bucks County. When the Argonaut program was implemented, it was traditional that policies were written with one rate for the Philadelphia five-county area (Territory I), and one rate for the rest of the state (Territory II). With four years of our own data, it appears that there may be merit in seeking a more equitable means of distributing premiums in order to more accurately reflect claim costs. The House of Delegates may wish to

direct the Commission on Professional Liability Insurance to pursue such a change.

Appendix L

Supplemental Report J
Board of Trustees and Councilors
(Referred to Reference Committee on Reports of Officers)

The Board of Trustees met on October 5 and the morning of October 6. The following are some of the key actions taken by the Board and are submitted for the information of the House.

(1) Amended and approved recommendations by the Council on Education and Science regarding physician manpower needs in Pennsylvania.

(2) Determined to seek meeting with Governor to discuss contractual arrangements between Department of Public Welfare and PAID Prescriptions, Inc., for the administration of a program for reimbursement to druggists for prescriptions furnished to Welfare recipients.

(3) Reviewed and approved Supplemental Report I to the House which deals with examination of current Argonaut rate structure and disclosure of information needed to review rate increases, as directed by Special Session of the House of Delegates.

(4) Authorized budget for membership certificates for all members with provision for yearly update which asserts the member to be in good standing and in conformance with post graduate educational requirements.

(5) Authorized up to $5,000 from Medical Defense Fund in order to proffer material support to a Philadelphia physician in his defense against a charge of homicide arising from the death of a patient during a surgical procedure.

(6) Approved a tentative budget for 1976.

(7) Authorized legal counsel to attempt to persuade the Secretary of Health to withdraw proposed clinical laboratory regulations purporting to cover physicians' offices labs and to bring suit to prevent implementation if negotiations fail.

(8) Reviewed and approved for distribution to the House of Delegates Supplemental Report G outlining impact of series of proposals to "screw up the system" which were referred for research to Board by the House of Delegates at its special session July 2-3, 1975.

(9) Authorized suit for damages on behalf of physician member against lawyers who filed a complaint alleging medical malpractice. The complaint improperly asked for a specific amount of damages ($350,000) and resulted in publicity prejudicial to the physician.

Appendix M

Supplemental Report
Council on Governmental Relations

In our annual report, which was prepared earlier in the year, we promised to write a supplemental report bringing the House "up to date" on some of the current legislation in which the Society has an interest. Although the legislative activity of the Society has been preoccupied with the malpractice bills, other legislation has not gone unnoticed. Here, then, is a brief explanation of those other measures and their positions:

Ambulances—S-46—This is the bill to upgrade the state's voluntary ambulance corps. This measure has passed the Senate and has been reported from the House Committee on Health and Welfare.

Anatomical Gifts—H-398—This bill will propose to permit possessors of drivers' licenses to indicate on those licenses that they are anatomical gift donors. The Society supports this, but is awaiting the introduction of a companion bill to "beef up" the Anatomical Gift Registry before urging action. This bill is in the House Transportation Committee.

Children—S-25—This is the latest version of the Society-supported "Battered Child" bill. It, too, has passed the Senate and is currently on the House calendar for action.

Comprehensive Health Planning—S-10, H-853—These bills are the very controversial Administration-backed "Comprehensive Health Care Act" which contain ingredients such as certificate of need, uniform accounting, rate review, reporting of hospital-based physicians, financial arrangements, etc. The Society has testified before the House Committee on Health and Welfare against its proposal. At this writing, sufficient pressure has been placed upon the members of the committee to keep the bill "bottled up." The last action taken by the House Committee was to table its proposal. S-10 was reported from the Senate Committee on Public Health and Welfare and has since been re-referred to the Senate Appropriations Committee, where, at this writing, the members do not seem inclined to want to release the bill to the floor.

Death—H-363—This bill would write into law a statutory definition of death. The Society has testified and cautioned against this as not having sufficient latitude for the physician. The bill remains in the House Judiciary Committee before which the Society has testified.

Drugs—H-473—This bill would create a drug utilization review council in the Department of Health, which would be required to compile a list of interchangeable drugs and make judgments concerning their bioavailability and bioequivalency. This bill has been the subject of a study by the Society's Committee on Therapeutics which has testified before the House Committee on Health and Welfare cautioning them about the bill.

Hearing Aids—H-513—This bill is similar to the model hearing aid legislation approved by the Academy of Ophthalmology and Otolaryngology. This bill remains in the House Committee on Consumer Protection, where informal hearings have been held.

Medical Practice—H-545, H-546—These measures are the so-called "Medical District Act" and the "Pennsylvania Medical Education Planning Act." The Society supports the second of these measures, the Medical Education Planning Act, and feels that the Medical District is unnecessary. The "Education Bill" has passed the House

and is currently before the Senate Committee on Public Health and Welfare.

Physicians' Assistants—S-306—This bill is the Society-drafted measure to give the State Board of Medical Education and Licensure regulatory authority over physicians' assistants' practice and training. It has passed the Senate and is before the House Committee on Professional Licensure.

The above list of bills are those which have occupied our time when we weren't pursuing a malpractice measure. There are others of interest, but they probably will not receive any attention during this year.

Appendix N

Supplementary Report
Committee on Relationships with Allied Professions

In its report to the House the Committee on Relationships with Allied Professions indicated that it had been meeting with representatives of the Pennsylvania Nurses Association in an attempt to draft a mutually agreeable statement on joint practice in time for presentation to this House of Delegates.

Your committee did arrive at such a statement. The statement was presented to our Board of Trustees. Our Board tabled it, feeling it may have gone too far in recognizing an "independent" role for nursing. The statement was presented to the Pennsylvania Nursing Association Board. The PNA Board modified the statement feeling that it did not go far enough in recognizing the "independent" practice of nursing.

In view of these developments your committee does not feel it appropriate or practical to submit these statements for your approval.

The Committee on Relationships with Allied Professions seeks your comments on the statement during the reference committee hearing for the committee's guidance during the next year.

Draft Statement on Practice
Pennsylvania Nurses Association and
Pennsylvania Medical Society

This statement embodies the guiding principles on elements of practice by physicians and nurses in any setting. The application of the following principles of practice will substantially improve the quality, availability and accessibility of heatlh care for the people of the Commonwealth.

- The provision of best possible health care of our fellow human beings is the reason for the existence of the medical and nursing professions.
- Mutual respect and recognition of the individual competencies of each professional is essential if the capabilities of each are to be utilized to the greatest benefit of the patient.
- The degree of professional responsibility and accountability vested in members of health professions depends on integrity, education, experience, competence, and licensure. Each practitioner should perform only those acts for which that person has been prepared and has demonstrated ability to perform.
- Medical and nursing services are complementary, each having distinct responsibilities and accountabilities. Each practitioner is responsible for the quality of care rendered in meeting those accountabilities. Such responsibility should include civil liability.
- Medical and nursing collaboration is essential for the well-being of the patient. Medical and nursing collaboration includes various independent, dependent, and cooperative arrangements, depending on the needs of the patient. The goal of any practice arrangement is to provide the best possible health care.
- Educational programs for the preparation of nurse practitioners for extended roles should be developed by nursing under the aegis of a graduate school of nursing preferably in collaboration with medicine.
- The areas of practice of the nurse practitioner functioning in an extended role by law must be jointly determined by the State Board of Medical Education and Licensure and the State Board of Nurse Examiners, since such practitioners sometimes function in the "grey area" between the independent practice of nursing and the independent practice of medicine. The joint determination should not be based on traditional roles, but upon the best interest of the patient. The nurse practitioner in the extended role and the physician must collaborate to ensure the patient has easy access to adequate health care.
- Approaches to medical and nursing care are dynamic and require a continuous updating of knowledge, skills and techniques. This mandates continuing education for physicians and nurses.
- It is advantageous to have more clinically oriented continuing education programs planned by and for both physicians and nurses.
- It is advantageous to have physicians and nurses affiliated in local joint practice commissions in order to provide a collegial advisory group and a channel of communications between the professions.
- It is important to maintain a flexible and innovative approach to the potential role realignment of nurses and physicians. Differences in recipient populations, in the delivery system, and in the number and kinds of practitioners serving a particular population will influence what each practitioner regularly does, within the limits of the law as defined in the medical and nursing acts.
- Basic nursing education—diploma, A.D., B.S.N. programs—should have as its primary objective the teaching of direct patient nursing care and should include adequate theoretical and technical skills to prepare the graduate of that program. This necessitates adequate clinical experience in the undergraduate years.

Appendix O

Supplemental Report
Council on Professional Relations and Services

(Referred to Reference Committee on Professional Relations and Services)

The 1974 House of Delegates approved a recommendation to hold a moratorium on the delinquent dues provision of the State Society for the year 1975. This was done in an attempt to encourage physicians who were dropped from membership for non-payment of dues to rejoin the Society without paying one year's delinquent dues in addition to the current year's dues. The council attempted to capitalize on this action by contacting all delinquent dues members by letter and was successful in attracting several back into membership. The results to date however, are rather inconclusive. Since the council is looking into a program which would use direct physician contact with non-members rather than simply a letter writing campaign, an extension of the moratorium may prove helpful. **Therefore, the Council on Professional Relations and Services recommends to the 1975 House of Delegates that an extension of the moratorium on delinquent dues be authorized for an additional year.**

The annual report of the council, which was prepared in early June, contains a proposal to develop a provisional membership category as a marketing tool to get physicians into organized medicine faster than under the current procedures. The recommendation was for some appropriate body to develop this new membership category. At its meeting in August, the Board of Trustees and Councilors reviewed a report of the council on the matter and requested that the council develop a complete proposal, giving special attention to all legal implications, since it had originated the idea and is most familiar with the expected results. The council concurs with this thinking and, therefore, **recommends that the proposal of the provisional membership program as outlined in the annual report be referred back to the council for development.**

Appendix P

Supplemental Report
Judicial Council

The Judicial Council met on Monday, October 6, 1975, to consider a referral from the Special Session of the House of Delegates, declaring it unethical for a physician to accept a fee for expert testimony, and referring the question to the Judicial Council for adjudication.

The council considers this a fascinating suggestion, but a wholly impractical one, and that the provision of expert medical testimony for a fee is not unethical. Some of the council's concerns were:

1. A physician may be called into court by subpoena, or as an alternative be requested to appear as an expert witness with an appropriate fee and with somewhat more latitude to arrange a convenient time for appearance. If the physician is merely deprived of a right to compensation for his time, would this eliminate a necessity or opportunity to testify, or is it assumed that under such duress all physicians would be counted on to be hostile witnesses?

2. A second concern stems from a feeling that the great bulk of "expert" testimony is indeed "expert" and serves the cause of justice.

3. The Judicial Council's final concern hinges upon the willingness of litigants, their attorneys, and the Legislature to accept the State Medical Society as the provider of testimony, and could the State Society provide experts as "friends of the court" who would be equally acceptable to both sides, or could the State Society provide experts on both sides of the case.

The remedy of this problem, if there is one, must be in changing the law, not in amending the medical society's code of ethics. A medical society cannot ensure that the law is administered with justice.

House of Delegates

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